

Library
National Institutes of Health
Bethesda 14, Maryland

RK301
.U522
1962
S

U.S. CONGRESS. SENATE. COMMITTEE ON LABOR
AND PUBLIC WELFARE.

CONTROL OF DENTAL DISEASES.



CONTROL OF DENTAL DISEASES.

HEARING
BEFORE THE
SUBCOMMITTEE ON HEALTH
OF THE
U.S. Congress. Senate. COMMITTEE ON
LABOR AND PUBLIC WELFARE.
UNITED STATES SENATE
EIGHTY-SEVENTH CONGRESS

SECOND SESSION

ON

S. 917

A BILL TO AMEND SECTION 314 OF THE PUBLIC HEALTH
SERVICE ACT TO PROVIDE A GRANT PROGRAM FOR THE
PREVENTION AND CONTROL OF DENTAL DISEASES, AND
FOR OTHER PURPOSES

MAY 24, 1962

Printed for the use of the
Committee on Labor and Public Welfare



U.S. GOVERNMENT PRINTING OFFICE

WASHINGTON : 1962

Library

National Institutes of Health

Bethesda 14, Maryland

RK301
U522
1962
5

COMMITTEE ON LABOR AND PUBLIC WELFARE

LISTER HILL, Alabama, *Chairman*

PAT McNAMARA, Michigan

WAYNE MORSE, Oregon

RALPH W. YARBOROUGH, Texas

JOSEPH S. CLARK, Pennsylvania

JENNINGS RANDOLPH, West Virginia

HARRISON A. WILLIAMS, JR., New Jersey

QUENTIN N. BURDICK, North Dakota

BENJAMIN A. SMITH II, Massachusetts

CLAIBORNE PELL, Rhode Island

BARRY GOLDWATER, Arizona

JACOB K. JAVITS, New York

WINSTON L. PROUTY, Vermont

JOHN G. TOWER, Texas

MAURICE J. MURPHY, JR., New Hampshire

STEWART E. MCCLURE, *Chief Clerk*

JOHN S. FORSYTHE, *General Counsel*

SUBCOMMITTEE ON HEALTH

LISTER HILL, Alabama, *Chairman*

RALPH W. YARBOROUGH, Texas

HARRISON A. WILLIAMS, JR., New Jersey

CLAIBORNE PELL, Rhode Island

JACOB K. JAVITS, New York

JOHN G. TOWER, Texas

ROBERT W. BARCLAY, *Professional Staff Member*

JOHN STRINGER, *Minority Associate Counsel*

CONTENTS

Text of S. 917-----	Page 1
Report from the Department of Health, Education, and Welfare-----	8

CHRONOLOGICAL LIST OF WITNESSES

Cohen, Wilbur J., Assistant Secretary for Legislation, Department of Health, Education, and Welfare; accompanied by Dr. Donald J. Galagan, Chief, Division of Dental Public Health and Resources, Public Health Service, and Sam Kimble, program officer, Bureau of State Services, Public Health Service-----	3
Hillenbrand, Harold, D.D.S., secretary, American Dental Association; accompanied by Joseph B. Kennedy, D.D.S., member, council on legislation; Bernard J. Conway, assistant secretary in charge of local affairs; Hal M. Christensen, Washington counsel, and Dr. C. Willard Camalier, director, Washington office-----	17
Lamar, Woodward D., D.D.S., Alabama State Dental Association; accompanied by B. J. Russell, executive secretary, Alabama State Dental Association-----	61
Young, Wesley O., D.M.D., M.P.H., vice president, American Society of Dentistry for Children-----	65
Ayers, Polly, D.D.S., director, Bureau of Dental Health, Jefferson County, Birmingham, Ala., representing American Association of Public Dentists-----	72
Davens, Edward, M.D., Deputy Commissioner of Public Health, Maryland State Department of Health, Baltimore, Md., representing American Public Health Association-----	80

STATEMENTS

American Dental Association, prepared statement-----	17
American Association of Dental Schools, prepared statement-----	127
Ayers, Polly, D.D.S., director, Bureau of Dental Health, Jefferson County, Birmingham, Ala., representing American Association of Public Dentists-----	72
Cohen, Wilbur J., Assistant Secretary for Legislation, Department of Health, Education, and Welfare; accompanied by Dr. Donald, J. Galagan, Chief, Division of Dental Public Health and Resources, Public Health Service, and Sam Kimble, program officer, Bureau of State Services, Public Health Service-----	3
Davens, Edward, M.D., deputy commissioner of public health, Maryland State Department of Health, Baltimore, Md., representing American Public Health Association-----	80
Hillenbrand, Harold, D.D.S., secretary, American Dental Association; accompanied by Joseph B. Kennedy, D.D.S., member, council on legislation; Bernard J. Conway, assistant secretary in charge of local affairs; Hal M. Christensen, Washington counsel, and Dr. C. Willard Camalier, director, Washington office-----	17
Prepared statement-----	60
Lamar, Woodward D., D.D.S., Alabama State Dental Association; accompanied by B. J. Russell, executive secretary, Alabama State Dental Association-----	61
National Health Federation, San Francisco, Calif., prepared statement-----	130
Perkins, John A., president, University of Delaware, prepared statement-----	84
Young, Wesley O., D.M.D., M.P.H., vice president, American Society of Dentistry for Children-----	65

ADDITIONAL INFORMATION

Articles entitled:	Page
"Dental Bureau Too Poor To Help Needy Children," from the Washington Evening Star of May 23, 1962-----	27
"Survey of State Dental Health Programs, Parts 1 and 2," from the Journal of the American Dental Association-----	60
Chart I.—Dental diseases—A lifelong problem-----	53
Chart II.—Tooth loss of people in the United States-----	54
Chart III.—Dental caries-----	55
Chart IV.—Periodontal disease—the major problem in adults-----	56
Chart V.—Utilization of dental services-----	57
Chart VI.—Persons with little education and low incomes receive less dental care-----	58
Chart VII.—Disparity between dental needs and services-----	59
Chart VIII.—Costs of dental disease-----	59
Letters and telegrams to Senator Hill from:	
Arnold, John M., D.M.D., acting director, Bureau of Dental Hygiene, Alabama Department of Public Health, Montgomery, Ala., dated May 22, 1962-----	86
Ast, David B., D.D.S., director, Bureau of Dental Health, New York State Department of Health, telegram dated May 31, 1962-----	114
Atkins, Walter D., D.D.S., director, Division of Dental Health, New Mexico Department of Public Health, Santa Fe, dated May 18, 1962-----	113
Baker, E. D., D.D.S., president, North Carolina Dental Society, Raleigh, telegram dated May 24, 1962-----	116
Bellinger, Willard R., D.D.S., director, Division of Dental Hygiene, Kansas State Board of Health, Topeka, Kans., dated May 24, 1962, containing copy of letter sent to Senators Carlson and Pearson-----	97
Bissell, D. M., M.D., president, California Conference of Local Health Officers, San Jose, Calif., dated May 18, 1962-----	89
Burgdorf, Alfred L., M.D., director of health, city of Hartford, Conn., telegram dated May 24, 1962-----	91
Busby, R. Ed., D.D.S., president, Mississippi Dental Association, Hattiesburg, dated February 6, 1962-----	105
Cannon, Joseph E., M.D., director of health, Rhode Island Department of Health, Providence, telegram dated March 29, 1962-----	121
Cassel, Carl V. E., D.D.S., secretary, Minnesota State Dental Association, St. Paul, dated May 22, 1962-----	105
Cassidy, James L., D.D.S., secretary-treasurer, Georgia Dental Association, Macon, Ga., dated January 24 and May 22, 1962-----	93
Cook, Paul, D.D.S., chief, Dental and School Health Section, Louisiana State Board of Health, New Orleans, dated May 21, 1962---	100
Coxwell, Dr. A. B., secretary, Kentucky Dental Association, Louisville, Ky., telegram dated May 18, 1962-----	99
Crane, Kenneth F., executive secretary, Wisconsin State Dental Society, Milwaukee, dated May 22, 1962-----	124
Dalglish, R. C., D.D.S., secretary, Utah State Dental Association, Salt Lake City, dated May 18, 1962-----	123
DeCamp, Floyd H., D.D.S., director, Florida State Board of Health, Jacksonville, Fla., dated May 22, 1962-----	92
Dore, George D., D.D.S., president, Legislative Interest Committee of the Dental Profession, Seattle, Wash., dated May 26, 1961-----	124
Downs, Robert A., D.D.S., M.S.P.H., chief, Public Health Dentistry Section, Colorado Department of Public Health, Denver, Colo., dated May 21, 1962-----	90
Drew, T. J., D.D.S., director, Division of Dental Health, Wyoming Department of Public Health, Cheyenne, dated May 24, 1962-----	125
Dwork, Ralph E., M.D., director of health, Ohio Department of Health, Columbus, dated May 22, 1964-----	117
Easlick, Kenneth A., D.D.S., professor of public health dentistry, University of Michigan School of Public Health, Ann Arbor, dated May 22, 1962-----	104
Fitts, Wendell E., D.M.D., director, executive council, New Hampshire Dental Society, dated May 24, 1962-----	112
Fulton, John T., D.D.S., vice president, American Board of Dental Public Health, dated May 22, 1962-----	129

Letters and telegrams to Senator Hill from—Continued

Gower, Stanley M., M.D., secretary, Maine Dental Association, Skowhegan, telegram dated May 24, 1962	Page 101
Gravalle, H. Roy, D.D.S., director, Division of Preventive Dentistry, State Department of Health, Oklahoma City, Okla., dated May 18, 1962	119
Grubler, William R., D.D.S., secretary, Wheeling District Dental Society, Wheeling, W. Va., dated July 17, 1961	124
Hamm, Don M., D.D.S., secretary-treasurer, Arkansas State Dental Association, Clarksville, Ark., telegram dated May 23, 1962	87
Hake, Homer N., D.D.S., secretary, Iowa Dental Association, Des Moines, Iowa, dated June 1, 1961	96
Hein, John W., dean, Tufts Dental School, Boston, Mass., telegram dated May 23, 1962	103
Henshaw, Charles H., D.D.S., director, Division of Dental Hygiene, Iowa Department of Public Health, Des Moines, Iowa, dated July 25, 1961	96
Hoffman, Olin E., head, Dental Health Section, Washington State Department of Health, Seattle: Telegram dated May 23, 1962	123
Letter dated June 6, 1961	124
Howell, Charles L., D.D.S., secretary, Indiana State Dental Association, Indianapolis, Ind., dated May 25, 1962	95
Hurley, Daniel J., M.D., State health officer, Nevada State Department of Health, Reno, dated May 18, 1962	109
Hutcheson, R. H., M.D., commissioner, Tennessee Department of Public Health, Nashville, dated January 4, 1962	122
Jeffreys, Margaret H., director, Division of Oral Hygiene, Delaware State Board of Health, Dover, Del., dated May 21, 1962	91
Koerner, R. L., D.D.S., chairman, Legislative Committee, Arizona State Dental Association, Phoenix, Ariz., dated May 23, 1962	87
Leland, Stanley J., M.D., New Mexico Department of Public Health, Santa Fe, telegram dated May 23, 1962	112
Livingston, Francis I., D.D.S., director, Bureau of Dental Public Health, New Hampshire Department of Health, Concord, dated May 23, 1962	110
Macalaster, Gordon G., D.M.D., New Hampshire Dental Society, Laconia, dated May 24, 1962	110
MacRury, Elwood F., D.D.S., Manchester, N.H., telegram dated May 22, 1962	111
Mansfield, Hon. Mike, a Senator from the State of Montana, dated May 10, 1961 enclosing a letter from G. D. Carlyle Thompson, M.D., executive officer, State board of health, Helena, Mont.	107
Melarkey, David W., D.D.S., president, Nevada State Dental Society, Reno, dated May 18, 1962	109
Merrill, Malcolm H., M.D., director of public health, California Department of Public Health, Berkeley, Calif., dated May 21, 1962	89
Metcalf, Hon. Lee, a Senator from the State of Montana, dated May 9, 1961, containing a letter from G. D. Carlyle Thompson, M.D., executive officer, State board of health, Helena, Mont.	108
Miller, Robert M., D.M.D., Manchester, N.H., dated May 24, 1962	110
Myers, Raymond E., dean, University of Louisville, Louisville, Ky., telegram dated May 23, 1962	99
O'Brian, E. E., D.D.S., chief, Division of Dental Hygiene, Ohio Department of Health, dated May 26, 1962	118
Opinsky, Jack, D.D.S., Hartford, Conn., telegram dated May 25, 1962	91
Osgood, S. B., secretary, Oregon Health Officers Association, Portland, telegram dated May 22, 1962	119
Pearson, Jr., E. A., director, Division of Oral Hygiene, North Carolina State Board of Health: Letter dated April 28, 1961	115
Telegram dated May 24, 1962	116
Perkins, John A., president, University of Delaware, Newark, Del., dated May 22, 1962	84
Peterson, Dr. Shailer, dean, University of Tennessee College of Dentistry, Memphis, telegram and letter dated May 23, 1962	121

Letters and telegrams to Senator Hill from—Continued

Pierson, F. A., D.D.S., secretary, Lincoln, Nebr., telegram dated May 25, 1962-----	Page 109
Phillips, Percy T., executive secretary, Dental Society of the State of New York, telegram dated May 29, 1962-----	114
Pope, Jr., Thomas W., D.D.S., president, Louisiana Dental Association, New Orleans, telegram dated May 30, 1962-----	100
Prather, Perry F., M.D., secretary, Maryland Department of Health, Baltimore, dated May 19, 1961-----	101
Purtell, Eugene P., D.D.S., secretary, New Mexico Dental Association, dated May 31, 1962-----	113
Ramos, Dr. Reinaldo Gonzalez, secretary, University of Puerto Rico School of Dentistry, San Juan, telegram dated May 24, 1962-----	121
Richmond, Fred A., D.D.S., secretary, Kansas State Dental Association, Kansas City, Kans., telegram dated May 23, 1962-----	97
Robinson, James R., consultant in dental health, State department of public health and welfare, Jefferson City, Mo., dated May 21, 1962-----	106
Schunick, William, D.D.S., secretary, Maryland State Dental Association, Baltimore, dated June 7, 1961-----	101
Short, J. Robert, DDS., president, Michigan State Dental Association, Lansing, Mich., telegram dated May 22, 1962-----	103
Siersma, George H., D.D.S., secretary, Colorado Dental Association, dated June 1, 1962-----	90
Striffler, David F., D.D.S., associate professor, University of Michigan School of Public Health, dated May 22, 1962-----	104
Suggett, E. D., D.D.S., secretary-treasurer, Missouri Dental Association, Jefferson City, dated May 22, 1962-----	106
Sullens, Reginald, secretary, American Association of Dental Schools, Chicago, Ill., dated May 25, 1962-----	127
Tingley, Harold E., D.M.D., secretary, Massachusetts Dental Society, dated May 28, 1962-----	102
Towler, S. Byron, D.D.S., secretary-treasurer, North Carolina Dental Society, dated June 28, 1961-----	116
Trithart, A. H., D.D.S., director, Division of Dental Health, Tennessee Department of Public Health, Nashville, dated May 24, 1962-----	122
Trubman, Aaron, D.D.S., supervisor, Public Health Dentistry, Mississippi State Board of Health, Jackson, Miss., May 21, 1962--	106
Truss, George V., executive director, Southern Branch of the American Public Health Association, Birmingham, Ala., dated April 26, 1961--	130
Venable, John H., M.D., director, Georgia Department of Health, Atlanta, Ga., dated May 22, 1962-----	94
Wilbar, C. L., Jr., M.D., acting president, Association of State and Territorial Health Officers, Harrisburg, Pa., dated May 22, 1962---	125
Williams, Dr. Floyd E., secretary, New Hampshire Dental Society, Manchester, dated May 23, 1962-----	109
Yoder, Franklin D., M.D., director of public health, Illinois Department of Public Health, Springfield, Ill., dated May 24, 1962-----	94
Letters from:	
Anderson, John S., executive officer, Montana State Board of Health, Helena, telegram to Senator Lee Metcalf, dated May 22, 1962-----	108
Baumgartner, Leona, M.D., commissioner of health, New York City, to Senator Jacob K. Javits, dated May 24, 1962-----	115
Clopper, Paul W. D.D.S., secretary, Illinois State Dental Society, to Hon. Barratt O'Hara, dated February 24, 1961-----	95
Frechette, Alfred L., commissioner, Massachusetts Department of Public Health, Boston, Mass., to Senator Benjamin A. Smith II., dated May 22, 1962-----	102
Greep, Roy O., dean, Harvard School of Dental Medicine, Boston, Mass., to Senator Benjamin A. Smith II., dated May 23, 1962-----	103
Hoag, Orvis S. acting chief, Division of Dental Health, Illinois Department of Public Health, Springfield, Ill., to Senator Paul H. Douglas, dated May 24, 1962-----	94
Jordan, William A., D.D.S., chief, Section of Dental Health, Minnesota Department of Health, to Senator Humphrey, dated May 22, 1962-----	105

Letters from—Continued

Lyons, Garrett B., chairman, legislative council, Delaware State Dental Society, Wilmington, Del., to Senate Committee on Labor and Public Welfare dated May 22, 1962-----	Page 91
Oxford, Donald E., D.D.S., chairman, Council on Legislation, Oklahoma State Dental Association, Oklahoma City, to: Senator Robert S. Kerr, dated May 25, 1962-----	118
Senator A. S. Mike Monroney, dated May 25, 1962-----	119
Paulson, Duane R., D.D.S., University of Oregon Dental School, Portland, to Senator Morse dated April 22, 1961-----	120
Peterson, John K., D.D.S., director Division of Dental Health State Department of Health, Bismarck, N. Dak., to Senator Quentin N. Burdick, dated May 21, 1962-----	116
Thomas, Robert J., D.D.S., president, Oregon State Dental Association, Portland, to Senator Morse, dated May 22, 1962-----	119
Wallace, David R., D.D.S., coordinator, dental health program, New Jersey Department of Health, Trenton, dated May 18, 1962, to: Hon. Clifford P. Case-----	112
Hon. Harrison A. Williams, Jr.-----	112
Wood, Ledru M., D.D.S., president-elect, Missouri Dental Association, Hannibal, Mo., to Senator Stuart Symington, dated May 31, 1962-----	106
National organizations which have adopted policies favorable to fluoridation-----	71
Table 1.—State dental health programs—sources of funds, fiscal year 1961-----	12
Table 2.—Per capita expenditures for dental public health and all public health, 1958–59-----	64

CONTROL OF DENTAL DISEASES

THURSDAY, MAY 24, 1962

U.S. SENATE,
SUBCOMMITTEE ON HEALTH OF THE
COMMITTEE ON LABOR AND PUBLIC WELFARE,
Washington, D.C.

The subcommittee met, pursuant to notice, at 10 a.m., in room 4232, New Senate Office Building, Senator Lister Hill, chairman, presiding.

Present: Senators Hill (presiding), Yarborough, Pell, and Javits.

Committee staff members present: Stewart E. McClure, chief clerk; John S. Forsythe, general counsel; Robert W. Barclay, professional staff member of the subcommittee; and John Stringer, associate minority counsel.

The CHAIRMAN. The subcommittee will kindly come to order.

The Subcommittee on Health of the Committee on Labor and Public Welfare is meeting this morning to consider S. 917 that I introduced to assist States and local communities in carrying out their programs to prevent and control dental diseases.

(S. 917 follows:)

[S. 917, 87th Cong., 1st sess.]

A BILL To amend section 314 of the Public Health Service Act to provide a grant program for the prevention and control of dental diseases, and for other purposes

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That (a) section 314 of the Public Health Service Act (42 U.S.C. 246) is amended by adding at the end thereof the following new subsection:

“(m) (1) To enable the Surgeon General to carry out the purposes of section 301 with respect to the prevention and control of dental diseases, there is authorized to be appropriated for each fiscal year such sums as are required to (A) assist, through grants, States, counties, health districts, and other political subdivisions of the State in establishing and maintaining adequate measures (including demonstrations, and training of personnel) for the prevention and control of dental diseases, and (B) to make project grants to public and other nonprofit agencies and organizations for surveys, studies, demonstrations, and training projects of regional or national significance in the prevention and control of dental diseases.

“(2) For each fiscal year, the Surgeon General, with the approval of the Secretary, shall determine the total sum from the appropriation under this subsection which shall be available for allotment among the several States under clause (A) of paragraph (1) and shall, in accordance with regulations, from time to time make allotments from such sum to the several States on the basis of the population and the financial need of the respective States. Upon making such allotments the Surgeon General shall notify the Secretary of the Treasury of the amounts thereof.

"(3) For each fiscal year the Surgeon General shall also determine, with the approval of the Secretary, the total sum from the appropriation under this subsection which shall be available for making project grants under clause (B) of paragraph (1) and may, upon recommendation of the advisory committee pursuant to paragraph (4), make such grants from such sum on such terms and conditions as he may prescribe. Payment pursuant to such grants may be made in advance or by way of reimbursement, and in such installments as the Surgeon General may prescribe.

"(4) The Surgeon General shall appoint an expert advisory committee composed of nine persons selected from among representatives of the dental profession (including leaders in the field of dental public health), representatives of other related health professions, and leaders in public affairs. Such committee shall advise him in connection with the administration of this subsection (m), including the development of program standards and policies and including, in the case of paragraph (3), recommendation to the Surgeon General of projects which it has reviewed and approved. Members of such committee who are not otherwise in the employ of the United States, while attending meetings of the committee or otherwise serving at the request of the Surgeon General, shall be entitled to receive compensation at a rate to be fixed by the Secretary of Health, Education, and Welfare, but not exceeding \$50 per diem, including travel time, and while away from their homes or regular places of business they may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by law (5 U.S.C. 73 b-2) for persons in the Government service employed intermittently.

"(5) Each appointed member of the advisory committee shall hold office for a term of three years, except that (A) any member appointed to fill a vacancy occurring prior to the expiration of the term for which his predecessor was appointed shall be appointed for the remainder of such term, and (B) the terms of the members first taking office after the date of enactment of this part shall expire as follows: Three at the end of three years after such date, three at the end of two years after such date, and three at the end of one year after such date, as designated by the Surgeon General at the time of appointment. None of the appointed members shall be eligible for reappointment within one year after the end of his preceding term."

(b) Subsection (f) of section 314 is amended by inserting after the phrase "the allotments to such State" the phrase "under any subsection of this section".

(c) Subsection (g) of section 314 is amended by inserting "or clause (A) of subsection (m) (1)", immediately preceding the phrase "as the case may be".

(d) Subsection (h) of section 314 is amended by striking "and" immediately preceding "(e)" and inserting "and clause (A) of subsection (m) (1)", immediately after "(e)".

(e) Subsection (i) of section 314 is amended by inserting "or clause (A) of subsection (m) (1)", immediately preceding the phrase "as the case may be".

(f) Subsection (1) of section 314 is amended by deleting "or (e)" and inserting in lieu thereof "(e), or clause (A) of subsection (m) (1)".

SEC. 2. Nothing in this Act shall prevent funds granted to a State under other provisions of Federal legislation from being available for the prevention and control of dental diseases in accordance with approved State plans applicable to such grants.

The CHAIRMAN. This bill would extend to dentistry the formula grants-in-aid that were initiated in 1936 and are now awarded by the Public Health Service on a matching basis with funds specifically designated to prevent and control venereal disease, tuberculosis, mental illness, cancer, heart disease, and chronic illness. The States contribute about \$9 for every \$1 of Federal funds they receive to finance programs developed by public health departments in cooperation with voluntary and private agencies and organizations.

In addition, the bill would authorize Federal appropriations to finance project grants to enable public and nonprofit agencies to conduct surveys, studies, demonstrations, and training to prevent and control dental disease.

I want to take this opportunity to pay tribute to the members of the dental profession for their leadership, their dedication, and their unceasing efforts in behalf of improving dental health. Dentistry itself was the first to recognize the need for the programs that would be authorized by S. 917.

We will have as our first witness the Honorable Wilbur J. Cohen, Assistant Secretary for Legislation, Department of Health, Education, and Welfare.

Mr. Cohen, we are glad to have you with us. And you may proceed in your own way.

STATEMENT OF WILBUR J. COHEN, ASSISTANT SECRETARY FOR LEGISLATION, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE; ACCOMPANIED BY DR. DONALD J. GALAGAN, CHIEF, DIVISION OF DENTAL PUBLIC HEALTH AND RESOURCES, PUBLIC HEALTH SERVICE; AND SAM KIMBLE, PROGRAM OFFICER, BUREAU OF STATE SERVICES, PUBLIC HEALTH SERVICE

Mr. COHEN. Thank you, Mr. Chairman.

I am pleased to have this opportunity to present the views of our Department with respect to S. 917, a bill to amend section 314 of the Public Health Service Act to provide a grant program for the prevention and control of dental diseases. Accompanying me this morning is Dr. Donald J. Galagan, Chief of the Division of Dental Public Health and Resources of the Public Health Service, and Mr. Sam Kimble, program officer, Bureau of State Services, Public Health Service, who are very familiar with existing programs and with new program opportunities in this field.

As indicated in our Department's report to your committee, we are in general accord with the objectives and approach of the bill, but we believe certain modifications and amendments would be desirable. I should like briefly to indicate why we believe an additional emphasis should be given in existing legislation to dental public health and to summarize our suggestions for modification of the provisions of S. 917 as introduced.

Dental diseases are the most prevalent of all the chronic diseases which afflict mankind. Tooth decay and diseases of the gums and supportive tissue are experienced by nearly everyone. Among young people, tooth decay is a particularly serious health problem. By the time the average child reaches his 15th year, 11 of his permanent teeth have been damaged or destroyed by tooth decay. Among adults, periodontal diseases are the major oral health problem, the principal cause of tooth loss.

Other dental disorders, though less prevalent, hold even more serious consequences for those affected. Cleft lip and palate—which occur once in every 800 live births—are disfiguring and crippling abnormalities. Today there are a quarter of a million individuals with cleft lip and palate, and 65,000 of these are under age 18. Malocclusion, which numbers one-half of all school children among its victims, often proves a severe handicap to the normal development of the child. The physiological effects of these disorders are obvious. Left untreated, they often produce psychological problems which may cripple the victims emotionally for life.

Oral cancer, which attacks 23,000 people a year, causes 1 in every 40 deaths from cancer. Early diagnosis and treatment would prevent many of these deaths.

Dental disorders are also the most neglected of all health conditions plaguing the American people. Each year, some 60 percent of the population receive no dental care at all, and others receive only the emergency services necessary for the relief of pain. As a result, 3 in every 10 people in the United States past the age of 35—and half of those past 55—are left with no natural teeth.

The full price that dental diseases exact from the Nation has never been totaled. We do know, however, that the cost is great. It is paid by industry in lost production and absenteeism; by the Armed Forces in meeting the massive backlog of dental needs existing among inductees; and by the public which spends \$2.4 billion a year to maintain a standard of dental health in which only 40 percent of the people visit a dentist even once in the course of a year.

We are concerned here with a group of diseases for which, generally speaking, there are no known cures. They are not self-correcting. Once they begin to attack, they can be controlled only through regular and continual treatment. Yet we are now entering a period when we can no longer assure that treatment will be available to all those who seek it. The dental manpower shortage is growing so severe that even if, over the next 20 years, we double our dental training facilities, we will do little more than prevent the shortage from reaching truly critical proportions.

To meet these needs effectively will require a threefold attack on the problem of dental diseases and conditions.

First, we need a continuing program of research into causes and methods of prevention and treatment of these diseases, coupled with programs for improved professional education in the dental sciences. The basic statutory and administrative structure for such a program of research and training was provided in 1948 through the enactment of legislation establishing the National Institute of Dental Research and the National Advisory Dental Research Council.

Mr. Chairman, in view of the key role which you have played in the enactment of this legislation and in the subsequent growth of the programs of this Institute, I am sure there is no need for me to describe the heartening progress that has been made or to emphasize

the need for continuing emphasis on this approach to improved dental health.

Second, it is unmistakably clear that the Nation's supply of professional dental personnel is not adequate to meet today's needs, and that—unless immediate measures are taken to increase this supply—we will be faced with even more acute manpower shortages in the very near future.

To help meet this critical need, as you know, we have submitted major legislative recommendations for expanding the enrollment capacity of our dental schools and for increasing the supply of qualified dental students. These recommendations—contained in S. 1072, the Health Professions Educational Assistance Act—have been discussed in previous hearings by your committee and need not be reviewed at this time. I should like, however, to repeat our belief that this legislation deserves the highest legislative priority and our hope that you will be able to take affirmative action on this most important legislation during the present session of Congress.

Third, there is need for stimulation and strengthening of community efforts—by public agencies and by professional groups and practitioners—to establish and conduct programs for the prevention and control of dental diseases; to achieve optimum utilization of available dental resources; to promote better public understanding and observance of the basic rules of good dental care; and to develop new and improved methods of dental health protection. It is this third approach—broadly defined as dental public health—that is the concern of the bill now under consideration by your committee.

Dental public health programs are by no means a recent innovation. On the contrary, most State and local public health agencies now conduct some programs in this field, but usually of a very limited character. While the scope and content vary greatly, they may include such activities as public health education in practical preventive measures and the essentials of good dental care maintenance; the provision of dental examinations; and in some cases, of corrective service for school children; and the establishment of clinical services for segments of the population with special needs or problems.

Despite the well-established value of such activities, dental public health programs today are grossly underemphasized in most State and local health agencies. In 1961 for example, the Public Health Service made general health grants of \$17 million to State public health departments. Yet these departments allocated to dental activities only \$125,000—just 0.7 percent of the total. Nor has this gulf been bridged by funds from other sources.

Of more than half a billion dollars spent in 1961 on all State health programs, only \$6.6 million—about 1 percent—went to dental health. This pattern of allocation of public health funds is in sharp contrast with that of private funds, where \$15 out of every \$100 spent for health care goes for the purchase of dental services.

So great a disparity cannot be ignored, for the current allocation allows less than 4 cents per person per year for all State and community activities in dental health. And 4 cents per person a year is simply not enough. It does not permit programs which even begin to meet the existing national need.

I might say parenthetically, Mr. Chairman, that the emphasis on dental health in our Department under the Kerr-Mills bill also is very limited, as well as the extent to which dental care is provided under voluntary prepayment plans. So, generally speaking, I would say dental care has been grossly underemphasized in all of these programs.

While there is no single device or approach that can remedy this underemphasis in every State and community, our experience with Federal grant-in-aid programs in other health fields has convincingly demonstrated that one effective approach is to provide increased Federal funds, on a matching basis, directed and earmarked for a specific activity or group of activities.

Without exception this approach has produced a twofold gain in the field of emphasis. First, the Federal funds themselves have given a new impetus to State and local programs. Second, and even more important, the matching fund requirement has resulted in increased funds from State and local sources—usually well beyond the minimum required for matching purposes. In our opinion, the need for increased attention to dental public health activities clearly justifies the initiation at this time of an earmarked grant for this purpose. And I would say, Mr. Chairman, such an earmarked grant would strengthen State and local and voluntary responsibility, and not in any way displace State and local funds.

In addition to an earmarked matching grant distributed among the States on a formula basis, experience with other public health programs also points to the need for a supplementary program of project grants aimed at developing and demonstrating new or improved program methods and approaches.

Projects of this type help to bridge the gap between laboratory research, on the one hand, and full-scale program application, on the other. Because such grant funds are related to specific projects initiated by public or nonprofit agencies, they are not distributed on a formula basis but are awarded on the basis of an evaluation of the merits of each project application, usually with the aid of an expert advisory body.

A project grant approach has been so successful in a number of fields that we believe it offers particular promise at this time in the field of public health dentistry.

The findings of expanded dental research are providing new leads for improved preventive and control measures and new approaches to dental health education and practices. Furthermore, the increasing shortage of dental personnel underscores the need for developing

better means of utilizing available professional personnel and for training professional personnel to employ these new and improved methods.

Among the many subjects or fields of special need for which special project grants might be most productive is the study of potential uses of auxiliary personnel to assist dentists; the development of methods of bringing effective dental care to such special groups as handicapped children; the improvement of dental health programs for schoolchildren, which is of great importance and value; the exploration of new methods for overcoming emotional difficulties that are obstacles to the use of available dental services; and experiments in the organizing and financing of dental services through voluntary prepayment plans that will encourage the more effective use of these services and their distribution among the people of the United States.

Mr. Chairman, this brief review of the dental public health problem and of the measures that seem appropriate for strengthening State and local programs in this field should make it clear that we are in basic agreement with the key proposals contained in S. 917—which would provide new legislative authority and leadership for both formula grants and project grants in the field of dental public health. As indicated in our report on the bill, however, we believe that the present provisions of the bill should be modified in two principal respects.

Instead of a new subsection of section 314 of the Public Health Service Act, as proposed in the bill, we believe that the authority for the formula grants should be derived from the existing provisions of section 314(c) of the act. As amended last year by the Community Health Services and Facilities Act, this subsection permits the earmarking of formula grant funds for specific purposes and provides for separate State matching of such earmarked funds.

We believe that this authority—if amended to eliminate the present appropriation ceiling of \$50 million annually—would be adequate for the purposes of S. 917 and would be preferable to a new and separate categorical grant authorization. With the appropriation ceiling removed, the problem could then be handled adequately each year by the Appropriations Committee, taking into account whatever the needs were year by year.

New statutory authority, along the lines of the provisions of S. 917, would be needed as the basis for dental public health project grants. We believe, however, that the present provisions pertaining to the appointment and functions of the new advisory committee would result in some statutory rigidity, and we recommend its replacement with a more flexible authorization for the appointment of such an advisory body.

With these minor modifications, Mr. Chairman, we believe that the bill has great merit, that it would bring great progress in the field of dental public health. We will be very glad to answer any questions at this time that you may have on this matter.

(The letter from Secretary Ribicoff to Chairman Hill follows:)

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
Washington, May 23, 1962.

HON. LISTER HILL,
Chairman, Committee on Labor and Public Welfare,
U.S. Senate,
Washington, D.C.

DEAR MR. CHAIRMAN: This letter is in response to your request of February 15, 1961, for a report on S. 917, a bill to amend section 314 of the Public Health Service Act to provide a grant program for the prevention and control of dental diseases, and for other purposes.

The bill would add to section 314 of the Public Health Service Act a new subsection which would authorize the Surgeon General (1) to make grants to States to assist them and their political subdivisions in establishing and maintaining adequate measures for the prevention and control of dental diseases, and (2) to make project grants to public and other nonprofit agencies and organizations for surveys, studies, demonstrations, and training projects of regional or national significance in the prevention and control of dental diseases. The Congress would be authorized to appropriate annually such sums as are required to carry out these purposes.

The Surgeon General would be required to appoint an expert advisory committee of nine members to advise him in connection with the administration of the grant programs authorized by the bill, including the development of program policies and standards and to recommend to him project grant applications which it has reviewed and approved.

The bill provides that the Surgeon General shall from time to time make allotments to the States from the sums which he, with the approval of the Secretary, has determined for each fiscal year to be available for grants to States. Such allotments would be made in accordance with regulations on the basis of the population and financial need of the respective States. The bill also makes technical amendments to subsections 314(f), 314(g), 314(h), 314(i), and 314(l) of the PHS Act to make the provisions of those subsections applicable in the administration of the new program of dental grants to States.

The Surgeon General, with the approval of the Secretary, would also be required to determine for each fiscal year the amount of the appropriation which is available for making project grants. He would be authorized to make such grants upon recommendations of the advisory committee on such terms and conditions as he may prescribe.

The bill directs that the provisions of the bill shall not prevent funds granted to a State under other provisions of Federal legislation from being available for the prevention and control of dental diseases in accordance with approved State plans applicable to such grants.

The need which the bill is designed to meet is clearly evident. Dental disorders are both the most common and the most neglected of all health conditions plaguing the American people. Each year, some 60 percent of the population receive no dental care at all, and others receive only the emergency services necessary for the relief of pain. As a result, 3 in every 10 Americans past the age of 35, and half of those past 55, are left with no natural teeth.

State and local health agencies which are charged with the major responsibility for preventing dental disease, educating the public to seek the services needed, and providing dental services for those individuals unable to care for themselves, have for many years worked against great odds. For example, in 1961 approximately \$6.6 million were spent by State health departments for dental activities. Yet it is estimated on the basis of a recent American Dental Association survey that there is an immediate need for a \$17 million annual expenditure to support dental activities, and that within 5 years, a \$29 million annual expenditure will be needed. The survey also points up the need for a five-fold increase in State health agency dental personnel. Additional financial sup-

port for dental programs obviously is required to accelerate and support the extension and strengthening of community services for the prevention and control of dental diseases.

S. 917 proposes to meet this need for stimulation and financial assistance in the development and maintenance of State and local dental programs through the authorization of a new Federal-State grant category for this purpose. A separate dental grant category would provide a basis for effective stimulation of needed State and local programs for the prevention and control of dental diseases.

We feel, however, that this purpose can more satisfactorily be achieved through use of the new authority enacted last year in the Community Health Services and Facilities Act for earmarking grant funds in the annual appropriation process. Under this authority, funds can be earmarked for use only in the prevention and control of dental diseases. The only amendment to existing legislation which would be required for this purpose would be to delete the annual appropriation ceiling of \$50 million now provided in subsection 314(c) of the Public Health Service Act.

The provision in S. 917 which would authorize the Surgeon General to make project grants to public or other nonprofit agencies and organizations would meet another longstanding and growing need. This provision would permit the Public Health Service to exercise national leadership and provide financial support to surveys, studies, demonstrations, and training projects of regional or national significance in the prevention and control of dental diseases. Projects supported under this authority would be those through which knowledge, techniques, and methods essential to the effective translation of research findings into active community dental programs would be developed and demonstrated.

New legislative authority would be necessary to enable the Surgeon General to make project grants for this purpose. We would concur, therefore, with the provisions of S. 917 relating to project grants, except for that portion of subsection (m) (3) which would limit the Surgeon General's authority to make such grants only to those projects which are recommended by the advisory committee. We recognize that the evaluation of project applications by an expert advisory committee such as is proposed in this legislation would provide very valuable assistance to the Surgeon General in making decisions with respect to the approval of project grants. We feel it is basically unsound, however, for such an advisory committee to be given authority to prevent the Surgeon General from approving a project which he, as the Federal official who is responsible for the effective operation of the program, decides should be approved.

We also question the necessity and desirability of requiring by legislation the establishment of another advisory committee. It would be preferable, in our judgment, to authorize, rather than require, the appointment of such a committee and not to prescribe in detail the composition, tenure, function, and compensation of the committee. Such an authorization would enable the Surgeon General to establish an advisory committee specifically for this program but would not require him to do so if he found that use of another advisory group already in existence or created in the future would be more feasible.

We would recommend, therefore, that the bill with the suggested amendments be enacted.

We are enclosing herewith, as required by Public Law 801, 84th Congress (5 U.S.C. 642a), a statement of estimated additional costs of the bill for the next 5 years.

We are advised by the Bureau of the Budget that there is no objection to the presentation of this report from the standpoint of the administration's program.

Sincerely yours,

ABRAHAM RIBICOFF, *Secretary.*

CONTROL OF DENTAL DISEASES

Grants for prevention and control of dental diseases (S. 917), estimate of additional, cost 1963-67

Item	1963	1964	1965	1966	1967
Appropriation requirements:					
Grants to States for prevention and control of dental diseases.....	\$5,000,000	\$7,500,000	\$10,000,000	\$12,000,000	\$13,000,000
Project grants for prevention and control of dental diseases.....	1,125,000	2,500,000	3,000,000	3,500,000	4,000,000
Subtotal.....	6,125,000	10,000,000	13,000,000	15,500,000	17,000,000
Administration costs.....	192,000	263,000	308,000	308,000	308,000
Total requirements.....	6,317,000	10,263,000	13,308,000	15,808,000	17,308,000
Expenditures:					
Grants to States for prevention and control of dental diseases.....	4,500,000	7,200,000	9,700,000	11,800,000	12,800,000
Project grants for prevention and control of dental diseases.....	500,000	2,500,000	3,000,000	3,500,000	4,000,000
Subtotal.....	5,000,000	9,700,000	12,700,000	15,300,000	16,800,000
Administration costs.....	182,000	256,000	303,000	306,000	306,000
Total requirements.....	5,182,000	9,956,000	13,003,000	15,606,000	17,106,000
Man-years of employment.....	23	32	37	37	37

The CHAIRMAN. Thank you, Mr. Secretary.

You say, with respect to the provisions of S. 917 regarding the advisory committee, you recommend—

its replacement with a more flexible authorization for the appointment of such an advisory body.

What do you have in mind particularly with reference to flexibility?

Mr. COHEN. Mr. Chairman, I don't know whether you put in the record our formal report on the bill. If not—

The CHAIRMAN. It will go in the record immediately following your statement.

Mr. COHEN. All right, Senator. Then I will read you the paragraph from that report which explains our position on it:

New legislative authority would be necessary to enable the Surgeon General to make project grants for this purpose. We would concur, therefore, with the provisions of S. 917 relating to project grants, except for that portion of subsection (m)(3) which would limit the Surgeon General's authority to make such grants only to those projects which are recommended by the Advisory

Committee. We recognize that the evaluation of project applications by an expert advisory committee such as is proposed in this legislation would provide very valuable assistance to the Surgeon General in making decisions with respect to the approval of project grants. We feel it is basically unsound, however, for such an advisory committee to be given authority to prevent the Surgeon General from approving a project which he, as the Federal official who is responsible for the effective operation of the program, decides should be approved.

We also question the necessity and desirability of requiring by legislation the establishment of another advisory committee. It would be preferable, in our judgment, to authorize, rather than require, the appointment of such a committee and not to prescribe in detail the composition, tenure, function, and compensation of the Committee. Such an authorization would enable the Surgeon General to establish an advisory committee specifically for this program but would not require him to do so if he found that use of another advisory group already in existence or created in the future would be more feasible.

The CHAIRMAN. Let me ask you this, Mr. Secretary. You spoke about the very small amount of funds going into dental activities, funds from the Public Health Service. There is a very small amount of funds going from the Children's Bureau, isn't there?

Mr. COHEN. Yes. I can give you those figures.

The CHAIRMAN. If you don't have them right now, you can supply them for the record.

Mr. COHEN. I have them here, and I can put all the figures in the record. They are interesting, Senator.

In fiscal year 1961 a total of only \$6,608,912 was spent on all State dental health programs. Now, that seems like a very, very small amount in connection with the tremendous need. Approximately \$4.5 million of that was State funds, about \$560,000 of that was local funds, and only about \$1.6 million was Federal funds. Interestingly enough, the States used more money from Children's Bureau funds than from Public Health Service funds for this purpose. Approximately \$1.2 million from the Children's Bureau's maternal and child health funds were used for dental activities, while the total used by the States from Public Health Service funds was only about \$359,000. It seems to us that when you look at what the tremendous needs are in this field, it is obvious that the State dental health programs are grossly undersupported.

(The table mentioned previously follows:)

TABLE 1.—*State dental health programs—sources of funds, fiscal year 1961*

State	Total funds	State	Local	Private	Federal funds					Children's Bureau	Other
					Total Federal	Public Health Service			Other PHS		
						Total PHS	General health				
Total.....	\$6,608,912	\$4,464,238	\$559,615	\$15,500	\$1,569,559	\$359,764	\$124,839	\$234,925	\$1,206,220	\$3,575	
Region I.....	287,684	181,752	6,903		99,029	41,870	15,064	26,806	57,159		
Connecticut.....	72,038	9,766			62,272	26,806		26,806	35,466		
Maine.....	33,538	30,185	3,353								
Massachusetts.....	87,513	72,749			14,764	14,764					
New Hampshire.....	32,923	21,088	3,550		8,285	300			7,985		
Rhode Island.....	35,948	22,240			13,708				13,708		
Vermont.....	25,724	25,724									
Region II.....	2,699,513	2,228,912	104,497		366,104	70,029		70,029	292,500	3,575	
Delaware.....	20,070	12,370			7,700				7,700		
New Jersey.....	275,224	109,490	104,497		61,237				61,237		
New York.....	1,390,769	1,237,452			153,317	55,179		55,179	94,563	3,575	
Pennsylvania.....	1,013,450	869,600			143,850	14,850		14,850	129,000		
Region III.....	1,254,601	761,916	352,465		140,220				140,220		
District of Columbia.....	383,800	383,800									
Kentucky.....	226,000	19,500	128,000		78,500				78,500		
Maryland.....	18,514	18,514									
North Carolina.....	293,505	154,040	103,465		36,000				36,000		
Virginia.....	305,000	184,000	121,000								
West Virginia.....	27,782	2,062			25,720				25,720		
Region IV.....	749,122	424,786	69,114	14,500	240,722	28,782		28,782	211,940		
Alabama.....	62,000	50,000			12,000				12,000		
Florida.....	90,050	30,500			59,550				59,550		
Georgia.....	90,032	45,016			45,016				45,016		
Mississippi.....	44,403	31,065			13,338				13,338		
South Carolina.....	89,901	33,205	11,060		45,636				45,636		
Tennessee.....	372,736	235,000	58,054	14,500	65,182	28,782		28,782	36,400		

Region V	401, 155	123, 371			277, 784	106, 913	106, 913		170, 871
Illinois	161, 782	73, 242			88, 540	84, 540	84, 540		4, 000
Indiana	74, 606	14, 125			60, 481				60, 481
Michigan	68, 571	34, 134			34, 437	6, 261	6, 261		28, 176
Ohio	46, 308	1, 370			44, 938				44, 938
Wisconsin	49, 888	1, 500			49, 388	16, 112	16, 112		33, 276
Region VI	187, 388	37, 793			149, 595	26, 668	26, 668		122, 927
Iowa	26, 200	4, 500			21, 700				21, 700
Kansas	19, 096	9, 547			9, 549				9, 549
Minnesota	65, 109				65, 109	21, 101	21, 101		44, 008
Missouri	33, 376	2, 200			31, 176				31, 176
Nebraska	15, 662	10, 882			4, 780				4, 780
North Dakota	26, 645	9, 364			17, 281	5, 567	5, 567		11, 714
South Dakota	1, 300	1, 300							
Region VII	236, 073	121, 107	16, 636	1, 000	97, 330	21, 314	2, 862	18, 452	76, 016
Arkansas	25, 000	25, 000							
Louisiana	22, 160				22, 160				22, 160
New Mexico	69, 731	46, 279	4, 000	1, 000	18, 452	18, 452	18, 452		27, 210
Oklahoma	63, 036	23, 190	12, 636		27, 210				26, 646
Texas	56, 146	26, 638			29, 508	2, 862	2, 862		
Region VIII	237, 205	102, 786	10, 000		124, 419	47, 888		47, 888	76, 531
Colorado	55, 339	26, 984			28, 355				28, 355
Idaho	105, 185	48, 485			56, 700	47, 888	47, 888		8, 812
Montana	27, 469	7, 512			19, 957				19, 957
Utah	13, 007				13, 007				13, 007
Wyoming	36, 205	19, 805	10, 000		6, 400				6, 400
Region IX	556, 171	481, 815			74, 356	16, 300	16, 300		58, 056
Arizona	14, 490	10, 000			4, 490				4, 490
California	90, 445	76, 946			13, 500	13, 500	13, 500		800
Hawaii	273, 391	272, 591			800				28, 908
Nevada	93, 540	61, 832			31, 708	2, 800	2, 800		1, 000
Oregon	46, 128	45, 128			1, 000				1, 000
Washington	38, 176	15, 318			22, 868				22, 868

Source: Digest of State Dental Health Programs, 1961, Public Health Service Publication No. 889.

Mr. COHEN. Now I say, Senator, I can speak with some feeling on that from our own experience in Michigan. I was a member of the State Board of Health of Michigan, and also chairman of the State public health advisory council, and I know that in my own State the State dental health programs are very grossly undersupported. We don't have a dental program in the State of Michigan for children on the aid to dependent children rolls. We don't have dental care in the part for the aged. We have an inadequate program. And here is Michigan one of the very high income States in the Union. From that experience I would say that if they don't have such a program other States in the Union would have great difficulty in financing such programs.

The CHAIRMAN. Mr. Secretary, isn't it true that the Public Health Service, the American Dental Association and the American Medical Association, and virtually every other major health organization have endorsed the fluoridation of water as a safe and effective means of preventing dental caries?

Mr. COHEN. That is my understanding, Senator.

The CHAIRMAN. And isn't it also true that none of the provisions of the pending bill, S. 917, would authorize the Department of Health, Education, and Welfare or its Public Health Service, to require States and communities to fluoridate their public drinking supply?

Mr. COHEN. That is correct. That would remain, as it is now, an optional matter with the States and localities to do in accordance with their policies and laws.

The CHAIRMAN. A matter to be determined entirely by the local communities?

Mr. COHEN. That is right.

The CHAIRMAN. Either by a direct vote of the people or by their elected chosen representatives, is that right?

Mr. COHEN. That is correct.

The CHAIRMAN. Senator Pell, any questions?

Senator PELL. Just one, sir. I notice from your statement that 3 out of every 10 people in the United States past the age of 35 and half of those past the age of 55 have no natural teeth at all. I wonder how that compare with figures from the countries of Western Europe.

Mr. COHEN. Dr. Galagan may have some information on that.

Dr. GALAGAN. Perhaps I can answer that, Senator Pell, at least in part.

Our record would compare favorably with northern European countries. The retention of teeth in the Scandinavian countries probably is better than it is in the United States. We would have a more favorable record than some of the English-speaking countries, England, Australia, and some of the others.

Senator PELL. How do you account for the fact that the Scandinavian countries have a better record, is it because of the better health service?

Dr. GALAGAN. In the Scandinavian countries there has been for many years a rather formal organized program of care for schoolchildren which would restore the decayed teeth during the time that the

children were in school, and this effort would lead to longer retention of their natural teeth.

Senator PELL. Thank you.

Mr. COHEN. Senator Pell, might I make a comment there that might interest you?

In World War II 50,000 draftees, the equivalent of 3 divisions, were rejected for dental reasons. It seems to me that this is an indication of what the need is here. And even at the present time it is estimated that each hundred military inductees need 20 dentures, 25 bridges, 80 extractions, and 505 fillings. Now, that gives an idea of the unmet needs of young men who are coming into the armed services now— young men who are otherwise healthy, intelligent, and able to render military service. And I think that gives you an idea of what an unfilled need there is in this country for both dental services and dental health education.

Another point that impresses me is this: About one-fifth, I think the figure is, of our population has never visited a dentist.

So you have an illustration from those two facts alone that more good dental public health programs are needed in this country.

The CHAIRMAN. Thank you.

Any other questions?

Senator YARBOROUGH. Mr. Cohen, I think the figure that you gave was 50,000 rejected for dental reasons?

Mr. COHEN. Yes; there were 50,000 draftees rejected for dental reasons.

Senator YARBOROUGH. Of course, that doesn't mean that a lot of those who were drafted didn't have very serious dental troubles.

Mr. COHEN. Yes. As I indicated, out of every 100 men inducted now, 20 need dentures, 25 need bridges, 80 need extractions, and there are a total of 505 fillings needed.

Senator YARBOROUGH. 505 fillings for what number of men?

Mr. COHEN. For 100 inductees, 505 fillings; roughly, 5 fillings per person.

Senator YARBOROUGH. I recall that there was a man drafted from Ohio and came into our division in the Southwest who didn't have a single tooth that he could chew with. So the division dental officer looked at him and said, "We will have to extract every tooth you have and make you some dentures."

The man disappeared that night and was caught trying to cross the Mississippi River. When he was brought back the dental officer wanted to court-martial him for desertion. But they couldn't get anybody to file charges. They all said, "If you were going to pull all my teeth, I would go a.w.o.l.; too."

But that just illustrates that that was one man without a single tooth who was drafted.

Mr. COHEN. There is one aspect that concerns me in my studies. I have found that, as people get older, the lack of natural teeth or even adequate dentures creates a serious problem. The whole problem of dental health care for our older population is something that we have

got to give increasing attention to. It is a problem of good nutrition and of good health. And, with our growing aged population, I think good public health education in the field of dental care is one of the most neglected activities in the whole field of health at the present time.

Senator YARBOROUGH. Mr. Chairman, I want to commend Secretary Ribicoff, Mr. Cohen, and the Department of Health, Education, and Welfare for the efforts they have made in the field of education, higher education and medical and dental education. I believe they have put forth great efforts toward this in less than a year and a half.

And, Mr. Cohen, I personally appreciate what you and your department and Secretary Ribicoff are trying to do to bridge some of these gaps in these badly neglected fields such as this, not merely for the people receiving the education, but on the broader basis for the Nation.

Mr. COHEN. As I said before you came in, Senator Yarborough, we are very hopeful that your committee can see fit to report out this other bill on the medical and the dental education. We look upon that bill and this bill as being related—the former being directed toward the development of manpower and this bill toward development of public health. And then, as I said earlier, with what we are doing through the National Institute of Dental Research, and the progress that has been made, in which Senator Hill has helped—the appropriations in that field are up to about \$19 million a year now—I think all these three things that we are doing are a very vigorous attack on this very important problem.

Senator YARBOROUGH. I agree with you. And I think the Secretary and you and your colleagues in the Department who have been working on this ought to be highly commended for the vigor and energy and drive that you have put into the support for this legislation.

Mr. COHEN. It is very nice for you to say it, Senator Yarborough, because we are not always commended for what we do.

Senator YARBOROUGH. I read the press, too.

The CHAIRMAN. Any further questions?

(No response.)

The CHAIRMAN. Is there anything you would like to add, Dr. Galagan?

Dr. GALAGAN. I think not.

The CHAIRMAN. Mr. Kimble?

Mr. KIMBLE. No, thank you.

The CHAIRMAN. Thank you.

And we have the Assistant Surgeon General, Dr. Ralph S. Lloyd, chief dental officer of the Public Health Service.

Is there anything you would like to add?

Dr. LLOYD. No. I am thoroughly in favor of the bill.

The CHAIRMAN. We are glad to have you with us this morning.

Next we have the members of the Council on Legislation of the American Dental Association. I am going to ask Dr. Joseph B. Kennedy, a member of that council, if he would come around and present to the subcommittee the spokesmen for the American Dental Association in behalf of the pending bill.

Would you come around, please, Dr. Kennedy?

STATEMENT OF HAROLD HILLENBRAND, D.D.S., SECRETARY, AMERICAN DENTAL ASSOCIATION; ACCOMPANIED BY JOSEPH B. KENNEDY, D.D.S., MEMBER, COUNCIL ON LEGISLATION; BERNARD J. CONWAY, ASSISTANT SECRETARY IN CHARGE OF LEGAL AFFAIRS; HAL M. CHRISTENSEN, WASHINGTON COUNSEL; AND DR. C. WILLARD CAMALIER, DIRECTOR, WASHINGTON OFFICE

Dr. KENNEDY. I am Dr. Joseph B. Kennedy, a member of the Council on Legislation of the American Dental Association. I do not have a statement to make. But I would like to introduce our very capable secretary, Dr. Hillenbrand of Chicago, who will present the views of the association on S. 917.

The CHAIRMAN. We are very glad to have you here, Dr. Kennedy. And we are also happy to have our good friend Dr. Hillenbrand here with us, and Dr. Camalier.

Now, would you also introduce the other members of your council so that we will have that in the record?

Dr. KENNEDY. Apparently you have heard from Dr. Camalier. He is in charge of our Washington office.

This is Mr. Conway, who is secretary of the association, for legal affairs.

The other members of our council are Dr. Alfred E. Smith of New Orleans; Dr. Francis Herz of San Francisco; Mr. Mathew Bousdine, the chairman of the council, from New York; Dr. Howard Niedhamer of Cincinnati; and Mr. Harvey Sarnier, assistant secretary, council on legislation.

The CHAIRMAN. We are glad to have all you gentlemen with us this morning. We appreciate very much your presence here.

Now, Dr. Hillenbrand.

Dr. HILLENBRAND. Mr. Chairman and members of the subcommittee, I would like also to present another member of the association staff, Mr. Hal Christensen, who is our Washington counsel.

The CHAIRMAN. Mr. Christensen is getting to be an old friend, too. It is nice to have you again, Mr. Christensen.

Dr. HILLENBRAND. I would like to submit our statement for the record and talk on it.

The CHAIRMAN. All right, sir.

(The prepared statement of the American Dental Association follows:)

PREPARED STATEMENT OF THE AMERICAN DENTAL ASSOCIATION

Mr. Chairman, members of the subcommittee, I am Dr. Harold Hillenbrand, of Chicago, Ill., secretary of the American Dental Association. I am accompanied by Dr. Joseph B. Kennedy of Des Moines, Iowa, a member of the association's council on legislation, Mr. Bernard J. Conway, the association's assistant secretary in charge of legal affairs, by Mr. Hal M. Christensen, the association's Washington counsel and Dr. C. Willard Camalier, director of the association's Washington office.

The American Dental Association, representing more than 80,000 practicing dentists, greatly appreciates this opportunity to testify in support of S. 917, a bill to provide a grant program for the prevention and control of dental diseases.

Over the years, the American Dental Association has consistently supported sound public and private programs to improve the dental health of our people.

The legislation creating the National Institute of Dental Research which was

sponsored by the distinguished chairman of this committee, received the vigorous support of this association, and since establishment of NIDR, the association has supported the increases in appropriations that have resulted in the development of an excellent dental research program at Bethesda and in the dental schools throughout the country. The association recognizes that in efforts of this kind, the Government has a legitimate interest and an entirely proper role. Without Federal participation, the rapid progress and significant advances in dental research would not have been possible.

The association also recognizes the need for Federal assistance if we are to overcome the extremely serious shortage of dental personnel that will occur in the next 15 to 20 years. Accordingly, the association strongly urges that the legislation (S. 1072) now pending before this committee be enacted at the earliest possible date. If legislation of this type is not passed, it will not be possible to construct the facilities necessary to train professional personnel to meet the dental care needs of our rapidly expanding and increasingly health conscious American population.

However, even with the enactment of S. 1072, the advances that can be expected in dental research and the new and more efficient techniques in dental treatment and care, additional private and public efforts will be necessary if the dental health of the public is to be improved and maintained at a reasonably acceptable level.

We are here today to ask the Congress to look at another important program area in dental health which is sorely in need of assistance. At the present time, there is no community in America that has an adequate dental public health program.

We are hopeful that the Congress will help us remedy this problem.

Despite the significant and rapid progress that has been made in the last several years in controlling dental disease, the total problem is of such dimension that it remains far beyond our ability to cope with it adequately.

Today, more than 160 million people in the United States have dental disease or face the almost certain prospects of suffering from tooth decay, periodontal disease, oral cancer, malocclusion, or cleft lip and palate. In fact, it is estimated that 97 million people have tooth decay; 23 million people have periodontal disease; 21 million people are without teeth; 16 million people have malocclusion; 1.2 million people have fluorosis or mottling of enamel; 65,000 children under 18 have cleft lip, cleft palate or both; 23,000 people develop oral cancer each year.

The following are some of the economic implications of dental disease: Personal dental health services cost \$24 billion per year—one-sixth of all money spent for personal health services, and it has been estimated that as many as 85 million man-hours of industrial production time are lost annually due to oral disease.

At the present time, the disparity between needs for dental care and services provided is far too great. The total amount of service rendered each year is not sufficient to treat the new dental needs occurring during the year. The accumulated backlog of need for dental service is so large that to remove it would require a year's full time service from a dental force five times its present size.

In addition, there is a great lag in the application of existing knowledge of preventive measures. For example, as of December 31, 1961, years after the effectiveness and safety of fluoridation had been demonstrated, only 2,193 communities with a combined population of 42.2 million persons were drinking fluoridated water. Only 34 percent of the people using central water supplies drink fluoridated water.

Still another great deficiency is the widespread lack of understanding of the value of regular dental care and of preventive measures which the individual himself can employ, such as oral hygiene and proper diet.

We look to our public health agencies to solve many of these problems but in the majority of States, dental public health programs are so seriously undermanned and underfunded that they are forced to operate at substandard levels. States which have the greatest need are forced to conduct their dental programs with only one or two dental health officers. As a result, there are far too few organized programs for bringing dental care to the aged and other homebound, the institutionalized, and the handicapped. Schoolchildren do not receive adequate dental health education, dental examination, diagnosis, and referral for treatment. There is a serious shortage of dentists trained to treat patients

with special physical or mental problems. Effective methods of preventing dental disease are being ignored to a disheartening extent by the general public.

I am not overstating the inadequacy of State dental programs. The need for substantial financial support has been fully documented by a survey completed in 1958-59 by the American Dental Association's Council on Dental Health, in cooperation with the American Association of Public Health Dentists.

The study was conducted to determine the extent and cost of State dental health programs and to determine need for their expansion in the interest of improving the dental health of the public. The study also was designed to show the specific types of programs that could be expanded or initiated if funds were available. Program data were reported for 43 States.

In order to make a meaningful tabulation of existing State activity and anticipated activity if funds become available, the study divided State public dental health programs into six main areas: (a) Program administration; (b) preventive, diagnostic, and corrective services; (c) program promotion and consultative services; (d) public health training and teaching; (e) dental health education and information; and (f) research and study projects.

Most States were found to be deficient in all of these activities but eager to expand them if adequate financial support were available.

For example, in the area of preventive, diagnostic, and corrective services, which includes treatment for indigent elementary school children, for the homebound, for those in nursing homes and for other physically handicapped, 98 percent of the States reported no program or an inadequate one. If funds become available, 75 percent of the States would initiate such programs. Expansion for these programs alone, only one of the six categories, would require almost three times the present State personnel in the first year and over six times the present personnel by the fifth year. The present State budgets would have to be increased over fivefold by the first year and eightfold by the fifth year. The difference between what States are actually doing in dental health and what they believe they should be doing is obviously very great. And the reason for the difference is not difficult to find.

On a per capita basis, the average State dental public health program yearly expenditure in 1958 was less than 2½ cents. In fact, eight States spent less than a penny per person each year for dental health. Also the study dramatically emphasized that dental health programs do not receive adequate support in relation to other State health department activities. For example, only nine-tenths of 1 percent of all health expenditures budgeted by State health departments in 1958-59 was for dental health programs. Two State health departments spent only one-tenth of 1 cent of each public health dollar for dental health.

We know that dentistry is in a very unfavorable position to compete for funds in State health departments and in general Federal authorizations. Even though dental diseases are serious and widely prevalent, they do not have the dramatic appeal of other diseases and do not arouse wide and intense public sentiment. In addition, dental programs frequently are in competition with medical programs which are covered by existing grant-in-aid authorization. In these situations, State and local legislators and public officials can hardly be criticized for favoring programs which have the advantage of specific Federal support. But, at the same time, we cannot continue to sacrifice the dental health of the American people because of a lack of dramatic appeal or an inequity in existing grant mechanisms.

By earmarking Federal grants for the prevention and control of dental diseases, the proposed legislation would remove the disadvantages which have made dentistry the stepchild of public health. With its passage, States would undertake activities which today are not receiving sufficient financial support: State health departments could extend the utilization of such preventive measures as topical fluoride applications, fluoridation of public water supplies, dietary control of dental decay; they could expand laboratory services to determine susceptibility to dental decay, to detect oral cancer. Services such as dental inspections of schoolchildren, radiographs, referrals to dentists for treatment, consultation with parents of preschool children through child health conferences, well-baby clinics and summer roundups could be increased and expanded. Dental care could be made available to persons living in remote areas of the country through the use of mobile dental units. Dental treatment could be made available to the indigent of all ages from preschoolchildren to adults; to those who are geographically isolated, homebound, or in nursing homes; to

those who are institutionalized, such as patients in tuberculosis hospitals, patients in mental hospitals, inmates of prisons and other correctional institutions.

Needed dental treatment to rehabilitate the handicapped could be provided—both specialized and routine treatment to correct cleft lips and palates, severe malocclusions, dentofacial deformities, and other physical handicaps.

State health departments could provide consultative services and financial assistance to local dental programs for employment of dental personnel, for support of dental preventive programs, dental education programs, and other dental program elements of local health departments. They could give inservice training to dental and other public health personnel at both the State and local level. They could sponsor or participate in lectures, seminars, conferences, workshops in public health, or allied subjects for private practitioners—dentists, dental hygienists, physicians, nurses. They could sponsor or participate in postgraduate and short courses in public health or allied subjects, such as dentistry for children, oral cancer, preventive orthodontics, at the college or university level.

Additionally, State health departments could promote and guide programs for teaching dental health in teacher training schools; they could participate in public health courses in nursing schools, in medical schools, in dental schools, in dental hygiene schools, in schools of public health, and very importantly, the public's understanding and knowledge about dental health could be expanded through the utilization of films, filmstrips, exhibits, and other visual aids, through the preparation and distribution of dental health education materials.

Finally, State health departments could undertake or expand epidemiological research and study projects to establish the nature and extent of dental diseases—dental caries, periodontal conditions, malocclusion, cleft lip, cleft palate.

What would it cost to achieve these things? It would cost a great deal more than most States are now willing to allocate, but it will cost very little when measured in terms of the huge benefits which the people of this country would derive from well developed and directed dental programs. Recent figures for fiscal year 1961 indicate that some \$6.6 million is budgeted by State health departments for dental public health activities. Yet, it is estimated from the association's survey made in 1958 that there is an immediate need for a \$17 million annual expenditure to support State dental activities, and that within 5 years, a \$29 million expenditure will be needed. As to personnel, 169 dentists were employed in fiscal year 1961 by State health departments. Of these, 96 were classified as public health dentists and 73 as clinical dentists. According to the American Dental Association's 1958 survey, 236 public health dentists, and 176 clinical dentists would be required in the first year, and 377 public health dentists, and 381 clinical dentists in the fifth year.

We must be realistic, however. There is little possibility that the necessary expansion and improvement can be achieved without the support and stimulus of Federal grants to State dental programs.

For the last several years, unsuccessful attempts have been made by State dental associations to induce State and local authorities to allocate the funds needed to do the job that has to be done. We are convinced, however, that Federal grants will supply the incentive and stimulation needed to induce more adequate State appropriations—that once such a grants program is initiated, financial participation by the States will actually begin to advance at a much faster rate than Federal participation. There is every reason to expect such an outcome. For example, between 1950 and 1960 the Federal contribution for mental health rose from \$3.5 million in 1950 and \$4.3 million, an increase of 23 percent, while over the same period, the local and State contributions rose from \$5 million to more than \$42 million, an increase of 740 percent. This has been the pattern regarding other categorical grants-in-aid programs and undoubtedly will be followed in the case of a dental disease program.

We of the American Dental Association, therefore, believe that enactment of S. 917 is essential to the achievement of a more satisfactory level of dental health.

Specifically, the bill provides for appropriation of Federal moneys to State and local governments for the establishment and maintenance of adequate measures for the prevention and control of dental diseases; and for project grants to public and nonprofit agencies for surveys, studies, demonstrations, and training projects for the prevention and control of such diseases. Project grants would be made by the Surgeon General with the approval of the Secretary of Health, Education, and Welfare, and, upon the recommendation of a special

advisory committee, may be made subject to terms and conditions as the Surgeon General shall prescribe. An advisory committee would be created to assist the Surgeon General in connection with the administration of this program. Allotment of funds to the several States would be on the basis of population and financial need and money allocated to the State or local political subdivisions would be matched by State and local funds. The use of these funds, as with other existing categorical grants programs, would be the prerogative of each State.

In 1949, the American Dental Association adopted a policy in support of a grant-in-aid program for the prevention and control of dental diseases. In 1956, the association renewed its support of the proposals now embodied in S. 917 by adopting the following resolution:

"Resolved, That the American Dental Association strongly recommends that Federal grants-in-aid specifically earmarked for dental programs be made to State health departments: and be it further

"Resolved, That the American Dental Association actively support this objective through appropriate legislative means."

The American Dental Association is reinforced in this support by several other professional organizations. The American Public Health Association in 1956 officially endorsed the legislation and currently offers its support. In addition, the Association of State and Territorial Health Officers, the Association of Public Health Dentists, the American Society of Dentistry for Children, and many State dental societies have officially endorsed this legislation as being desirable and in the public interest.

The Chairman and members of the committee, the dental health problem is great. State dental health programs have an important role to play in its solution, but to perform properly, these programs require greatly expanded financial support. Matching grants will help provide this support and will stimulate greater support at the State and local levels.

A project grant program also is required partly as a supplement to the matching grants for support of special kinds of activities by State dental health agencies but more importantly to permit our universities and other competent organizations to direct their attention to this field.

It is the association's firm conclusion that enactment of S. 917 would provide the stimulus that is necessary to inaugurate and expand the dental public health activities that are needed in all parts of the country.

In concept, the program fits in perfectly with the emphasis which the President placed upon the importance of expanding community health services in his special health message to Congress last year. Additionally, the program would supplement the President's program for improving the health care of our children and youth. The American Dental Association respectfully requests this committee to take favorable action on S. 917 at the earliest possible date.

Dr. HILLENBRAND. You will be interested to know that I was down before Congress on a similar mission almost 23 years ago to this day requesting grants in aid for dental programs in State health departments. I would hope that I will not have a similar charge 23 years from now.

The CHAIRMAN. I might say that Senator Yarborough and I were not members of the subcommittee at that time.

Dr. HILLENBRAND. The American Dental Association represents more than 80,000—

The CHAIRMAN. I am glad you said what you did, Doctor, to be frank about it, because I want to emphasize the fact that this legislation before us now, this proposal, for the prevention and control of dental diseases, is the child of our doctors of dentistry, the members of the American Dental Association.

Senator YARBOROUGH. I might say to the doctor, Mr. Chairman, that if Senator Hill had been chairman of the committee this long you could have stopped coming 10 or 12 years ago.

Dr. HILLENBRAND. I would be delighted not to come again on this mission, Senator.

The American Dental Association represents more than 80,000 practicing dentists, and we appreciate the opportunity to testify on S. 917, a bill to provide a grant program for the prevention and control of dental diseases.

Over the years the association has supported public and private programs to improve the dental health and needs of the country. You are familiar with the fact that we supported legislation to establish the National Institute of Dental Research, with some distinguished assistance from Senator Hill. We have since then routinely supported the increased appropriations. And we think the excellent program at Bethesda today is a tribute to what this legislation has done for the dental health of this country.

We believe that the Government has a legitimate and proper role in the improvement of dental health. We also believe that without Federal participation the advances that we have made in research in the last decade would have been quite impossible.

The association recognizes that there is also a need for Federal assistance in what we are going to need to meet an increasingly serious shortage of dental personnel. There is presently a bill pending, S. 1072, which would help in part to correct this situation by providing funds for the construction of dental schools and dental facilities. If this bill is not passed, I think the profession faces a very serious shortage of dental personnel in the face of a mounting dental health problem.

I think the failure to enact the construction bill will severely handicap our public schools. And of great concern to the association is the fact that it will probably begin to eliminate some of the private dental schools in this country.

Without research and construction, therefore, we feel that our present status would be even worse than it is.

We think now we need to bring some of the advances made in the laboratories directly to the people, so that they may be beneficiaries in the dental health program, so that Mr. Cohen and his successors will not have to report in the future what he has reported to the subcommittee this morning.

It is estimated that there are 97 million people with tooth decay; 23 million people with what we call periodontal diseases, which are diseases of the gum tissue; and 21 million people without teeth; 16 million with malocclusion; 1.2 million with fluorosis; 65,000 of our citizens under 18 who have cleft-lip palate, which you will recognize is a very serious deformity; and 23,000 of our people who develop oral cancer each year.

It seems to me, Mr. Chairman, that the economic implications of dental diseases are great for the United States.

Personal dental health services cost approximately \$2.4 billion each year, one-sixth of the amount spent for all personal health services.

We estimate that there are 85 million man-hours of industrial production time lost annually simply because of oral diseases.

At present there is a great span between need and the amount of services rendered. For example, the total annual service now rendered by the dental profession in this country would not be sufficient to meet new dental needs each year. If we tried to treat the accumulated need, which presently is an impossibility, it would require

the entire existing work force for 1 year plus an additional five times this work force. So I think we can agree that there is a great lag in applying existing knowledge to preventive measures. In language that I am sure you understand, Senator Hill, we are not farming half as well as we know how to farm.

For example, at the end of 1961, after fluoridation had been demonstrated as safe, effective, and economical, only 2,193 communities, with populations combined of 43 million, were drinking fluoridated water supplies.

Yesterday I had the privilege of presiding at a conference which celebrated the inauguration of fluoridation in the city of Evanston 15 years ago. And if you had heard the reports that I did as to what a single program had done for the dental health of Evanston, I think you would wonder why we haven't gone forward more rapidly in this program.

Only 34 percent of the cities with central water supplies are drinking fluoridated water.

I think there is a great lack of appreciation of regular dental care, and I think this is evidenced in the statistics which Mr. Cohen gave you on our inductees during the war. In many cases I think the service was available, except that people were not motivated to go to the dentist.

We believe that public dental health can solve some of these problems. And our mission here today is to tell you that the dental public health programs are seriously undermanned. In the last 5 years all of the States could not even have a single dentist on their State department of health, and only in the last 5 years can we now say that 50 States have State dental directors. The result is, as you can imagine, that there are few programs for dental care to the aged and to the homebound, to the institutionalized, and to the handicapped. Our schoolchildren do not get adequate dental health education, nor do they get dental examinations, diagnoses, and referrals. In addition, there is a serious shortage of dentists in the field of public health, and surely there is a shortage of dentists now in the field of public health and in private practice who are equipped to meet problems that are involved in special physical and mental types of patients.

I don't think that I am overstating this problem, because the need was rather well documented by our survey conducted by the American Dental Association and the American Association of Public Health Dentists in 1958-59. We tried to learn something of the extent and the cost of the current programs and the programs which could be developed or expanded. Forty-three of the States replied to this questionnaire. And we think the results of this questionnaire dramatically indicate that dental programs do not receive adequate support in relation to others. And there are perhaps some good reasons for this. Dental diseases do not immediately produce death or disabling illness, with the result that they are postponed and do not receive full public consideration.

We tabulated six areas in this study, and some of the facts will be of interest to the subcommittee. Ninety-eight percent of the States have either no programs or inadequate programs for indigent ele-

Education, and Welfare, and, upon the recommendation of a special advisory committee, may be made subject to terms and conditions as created to assist the Surgeon General in connection with the administration of this program. Allotment of funds to the several States would be on the basis of population and financial need and money matched by State and local funds. The use of these funds, as with other existing categorical grants programs, would be the prerogative of each State.

As I indicated at the outset, Mr. Chairman, the association has long been interested and active in this program. In 1949 the American Dental Association adopted a policy in support of a grant-in-aid program for the prevention and control of dental diseases. In 1956, the association renewed its support of the proposals now embodied in S. 917 and H.R. 4742 in a resolution adopted by the house of delegates.

This bill, as you will find this morning, is supported by the Association of State and Territorial Health Officers, the Association of Public Health Dentists, the American Society of Dentistry for Children, and many other State dental societies and many other groups.

Mr. Chairman and members of the subcommittee, I hope that I have made clear on behalf of the American Dental Association and its members that dental health in this country is a problem, and a very grave problem. We believe that the State dental programs have an exceedingly important role in the solution of this problem, but that these programs need Federal support. Matching grants would provide, and I am sure stimulate, such support. A project grant program also is required to support the special activities by States, but more importantly, to permit universities and others to direct attention to this much neglected field.

It is the association's firm conclusion that enactment of S. 917 would provide the stimulus that is necessary to inaugurate and expand the general public health activities that we have in all parts of this country.

In concept, the program fits in perfectly with the emphasis which the President placed upon the importance of expanding community health services in his special health message to Congress last year. Additionally, the program would supplement the President's program for improving the health care of our children and youth, in which he is much interested. The American Dental Association respectfully requests this committee to take favorable action on S. 917 at the earliest possible date and relieve what is becoming an increasingly difficult national health problem.

I should like, Mr. Chairman, for your information also to introduce some supplemental material into the record.

I appreciate the opportunity to address the committee on behalf of this extremely important legislation.

MR. CHAIRMAN. We would be happy to have that supplemental material, and it will appear in the record immediately following your statement along with an article from the Washington Evening Star of May 23, 1962. And I want to thank you, sir, for a very fine statement.

(The material referred to follows:)

Survey of State Dental Health Programs Part 1 and Part 2

COUNCIL ON DENTAL HEALTH

Reprinted from

Volume 61

Pages 599-605

November 1960

Pages 731-748

December 1960

THE JOURNAL OF THE AMERICAN DENTAL ASSOCIATION

Survey of state dental health programs: Part 1

COUNCIL ON DENTAL HEALTH

A survey of state dental health programs was conducted by the Council on Dental Health in 1958 and 1959¹ to determine their extent and cost, to demonstrate the need for their expansion in the interest of improving the dental health of the public and to show specific types of programs that could be initiated or expanded if funds were available. It was anticipated that the findings from such a study would provide state dental societies with documentation to support the need for increased appropriations from state legislatures and the Association with like justification for supporting the establishment of a dental category in the federal grants-in-aid program. The anticipated findings have been confirmed by the survey.

The Council had found previously that in those states which have the most effective dental divisions and the best dental public health programs, the state societies had actively supported the programs and assisted in procuring the necessary appropriations.² Effectiveness of cooperation between the state dental society and the state dental division has been demon-

strated further by the survey. The "State Dental Division, Program Survey and Cost Estimate Form" developed for the survey by the Council in cooperation with the American Association of Public Health Dentists was completed as a joint effort by the state dental society and state dental division in 46 states and territories, the latter being Puerto Rico and the Virgin Islands. In a few states where the form was prepared by the state dental division, support of the dental society for the proposed expansion of programs on the basis of increased public funds was assured.

HISTORICAL BACKGROUND

Having recognized grants-in-aid as an acceptable method of supporting public health programs "provided that the right of the state or community to adapt any program to its own needs is safeguarded,"³ the Association has taken steps over the years to bring about the establishment of earmarked federal funds for dental programs. In 1952, the following statement was adopted:⁴

Grant-In-Aid Funds. A historic method for assisting the individual states in the discharge of certain responsibilities to the public will be found in the grants-in-aid made by the federal government. These grants have been utilized for many decades and, by and large, have been established as effective means for attaining specific objectives without impairing the traditional rights of states and communities to determine and administer their own programs.

Grants-in-aid have been made by the federal government for many years for health purposes but it is significant that, at the present time, only 0.4 per cent of the total grants made by the U.S. Public Health Service are allocated to dental programs. Dentistry in many states is not considered as a "basic health service" and thus is automatically deprived of grants-in-aid which are made for basic health services. In order to overcome this difficulty, dentistry should consider the adoption of a program of fostering earmarked funds as has been done successfully for the programs to improve mental health, to procure control of cancer, venereal disease, tuberculosis and heart disease, to treat crippled children and to improve maternal and child health.

Such earmarked grants-in-aid are definitely circumscribed by law to permit the federal government to provide funds to state health departments for a specific purpose, such as the improvement of dental health. In return, the state must submit a written plan which outlines in an acceptable manner the details of the program in which such funds will be spent. A new plan must be submitted each year and thus there is an opportunity for a review of the program and its termination when such action is desirable. [The policy has since been revised. A new plan must be submitted once every two years.]

The House of Delegates of the American Dental Association has long held to the following policy for the improvement of state dental health programs:

Each of the states should be urged to establish a division of dental health within the department of health, and the administration of the dental program should be in the hands of a qualified dental officer who is directly responsible to the state health officer.

The Association can now advance its program materially by fostering earmarked grants-in-aid to state health departments for dental purposes and by urging the constituent societies to renew their efforts to obtain satisfactory administrative status for the dental unit in the state health department.

In 1953 and 1954, elimination of all

special disease grant-in-aid categories, such as the mental health, venereal disease and tuberculosis provisions of the Public Health Service Act, was urged by the then new Eisenhower Administration.⁵ It recommended substitution of a general grant-in-aid category, with the states deciding the public health purpose for which the available funds would be used. In view of the Administration's opposition to the entire categorical scheme, the Council on Legislation decided it would be inopportune to press for an additional category. Accordingly, the Council testified in 1953 in favor of the proposed elimination on the ground that state dental divisions would have some chance to obtain federal funds from a general grant source, none under the categorical scheme. With the beginning of President Eisenhower's second term, however, there was no express recommendation for eliminating categorical grants-in-aid, and the program was not discontinued.

In 1956, several state dental societies adopted resolutions calling for the American Dental Association to seek legislation for the establishment of a dental category in the program of federal grants-in-aid to states for general health activities. These resolutions requested further that appropriations to support such a category be sought. The House of Delegates that year referred the following resolution to the Council on Dental Health for action:⁶

Resolved, that the American Dental Association strongly recommends that federal grants-in-aid specifically earmarked for dental programs be made to state health departments, and be it further

Resolved, that the American Dental Association actively support this objective through appropriate legislative means.

The Councils on Legislation and Dental Health recognized that accomplishment of the foregoing objective would require extensive effort to win legislative support. It was decided that the Association first should develop:¹

1. A documented presentation of the present state dental health programs and the need for both immediate and future expansion of current programs

2. Suggestions for cooperative programs for state dental societies and state dental divisions that could be assured of the enthusiastic support of all of the dentists in the state in—

a. Informing state legislators and the public of the benefits of an expanded dental health program

b. Informing Congressmen of the benefits which would be derived from federal funds made available through a dental category.

The 98-item questionnaire "State Dental Division Program Survey and Cost Estimate Form" was the result. It requested information on the extent of current programs and their cost and on new programs that could be developed or existing ones that could be expanded in two years and in five years if funds were available.

METHOD OF TABULATION

Although information was received on 98 program items, it was obvious that consideration of all of them would make for an unwieldy analysis. Some all-inclusive tables would have to be presented to establish proper perspective on the entire state program, but a detailed analysis would not be feasible. Program activities viewed by state dental directors as those of greatest need would be the areas in which an expansion of funds could be expected, so it was decided to determine which these activities were and to concentrate on them. Therefore, the states were arrayed in order of percentage of proposed expansion, from maximum to minimum. The top three percentages were selected within each of the six program areas resulting in 18 items for those states contemplating initiation or expansion within the first year and another 18 for those contemplating initiation or expansion

within the second to the fifth years. On consolidation, there was an overlap of three items which reduced the list to 33 items in which initiation or expansion of program might be planned: four in the field of "Program Administration"; six in "Preventive, Diagnostic and Corrective Services"; five in "Program Promotion and Consultive Services"; six in "Public Health Training and Teaching"; six in "Dental Health Education" and six in "Research and Study Projects."

In order to give consideration to the influence of regional location on types of programs undertaken, the United States was divided into four regional areas. Their geographic composition is that used by the National Health Survey in Bureau of the Census surveys and in other studies.

Program data are reported for 43 states; budget and personnel data for 42. Puerto Rico and the Virgin Islands were excluded from consideration, because they could not readily be added to a regional analysis. Program data are included for Vermont, but personnel and budget data could not be extracted from its report. In view of the advent of a new program director in Rhode Island, no expansion was reported in that state. Since its inclusion would, therefore, distort the findings when percentages for the regions were expressed, Rhode Island was omitted entirely.

Personnel and budget data were extracted directly from the individual state returns so that the findings could be expressed on a regional basis. Editing of the returns was held to a minimum, but in some instances, for example, New York and Indiana, the figures were not cumulative and were adjusted to conform with the other state reports before data were consolidated. Additionally, data for the Northeast Region were adjusted arbitrarily to allow for seeming misinterpretation in the completion of findings on expansion in the Connecticut report.

The 43 states included in the tabulation are as follows, by region:

Northeast — Connecticut, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Vermont.

North Central—Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, Wisconsin.

South—Alabama, Arkansas, Delaware, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, West Virginia.

West — California, Colorado, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, Hawaii.

The 33 priority program activities which states have indicated for immediate initiation or expansion follow:

PROGRAM ADMINISTRATION

- A1 Liaison and cooperation in dental health matters with other services and units within the State Health Agency (for example, Nutrition, Engineering, Statistics, and so on).
- A2 Liaison and cooperation in dental health matters with other official and voluntary organizations and agencies outside of the State Health Agency (for example, welfare, medical and dental organizations, Congress of Parents and Teachers, education organizations, and so on).
- A3 Determining and publicizing private practice opportunities in low economic and isolated areas.
- A4 Compilation of adequate dental program statistics (for records, legislature purposes, program planning, program evaluation, and so on).

PREVENTIVE, DIAGNOSTIC AND CORRECTIVE SERVICES

- B3 Promotional efforts on a local level to encourage the acceptance and adoption of fluoridation of communal water supplies.
- B10 Provision of diagnostic services:
—referral programs (for example, inspection, roentgenograms, consultation with students or parents, use of referral cards, and so on).
- B12 Dental treatment for the indigent:
—elementary school children.

B16 Dental treatment for those who are:
—homebound.

B17 Dental treatment for those who are:
—in nursing homes.

B26 Dental treatment and rehabilitation of the handicapped:
—provision of treatment for other physically handicapped individuals.

PROGRAM PROMOTION AND CONSULTATIVE SERVICES

- C1 Provision of consultative services to local dental programs.
- C2 Provision of financial assistance to local dental programs for employment of full-time dental personnel.
- C4 Provision of financial assistance to local dental programs to support dental preventive programs.
- C5 Provision of financial assistance to local dental programs to support dental educational programs.
- C6 Provision of financial assistance to local dental programs to support other dental program elements of local health departments.

PUBLIC HEALTH TRAINING AND TEACHING

- D1 Provision of in-service training to state dental staff.
- D7 Sponsorship or participation in lectures, seminars, conferences, or workshops in public health or allied subjects for private practitioners:
—nurses.
- D8 Sponsorship or participation in postgraduate and short courses in public health or allied subjects (for example, dentistry for children, oral cancer, preventive orthodontics) at college or university level.
- D11 Provision of externships or preceptorships in public health for recent dental graduates.
- D12 Provision of organized job orientation programs for new personnel.
- D13 Teaching dental health in teacher training schools.

DENTAL HEALTH EDUCATION AND INFORMATION

- E1 Utilization of newspaper, radio or television or both to acquaint the public with dental health activities within the State.

Table 1 • Per capita expenditures for dental public health and all public health

States	Per capita expenditures		Per cent of all health expenditures devoted to dental health
	Dental public health programs	All public health programs	
United States	.024	2.54	0.9
Alabama	.017	2.00	0.8
Arkansas	.009	1.82	0.5
California	.005	3.05	0.2
Colorado	.028	2.37	1.2
Connecticut	.024	2.35	1.0
Delaware	.046	2.52	1.8
Georgia	.100	3.22	3.1
Hawaii	.031	7.75	0.4
Idaho	.047	2.17	2.2
Illinois	.020	1.62	1.2
Indiana	.016	1.29	1.2
Iowa	.008	1.12	0.7
Kansas	.012	1.71	0.7
Kentucky	.064	2.17	2.9
Louisiana	.012	2.64	0.5
Maryland	.076	3.89	2.0
Massachusetts	.011	2.79	0.4
Michigan	.013	2.44	0.5
Minnesota	.015	1.69	0.9
Mississippi	.011	2.18	0.5
Missouri	.003	2.05	0.1
Montana	.102	1.83	5.6
Nebraska	.010	1.27	0.8
Nevada	.255	3.02	8.4
New Hampshire	.044	1.92	2.3
New Jersey	.015	2.17	0.7
New Mexico	.050	2.55	2.0
New York	.007	4.69	0.1
North Carolina	.055	2.44	2.3
North Dakota	.031	2.21	1.4
Ohio	.004	1.99	0.2
Oklahoma	.031	2.07	1.5
Oregon	.018	2.54	0.7
Pennsylvania	.061	2.45	2.5
South Carolina	.045	2.20	2.0
Tennessee	.069	2.39	2.9
Texas	.006	1.87	0.3
Utah	.038	2.29	1.7
Virginia	.043	3.06	1.4
Washington	.012	2.71	0.4
West Virginia	.011	1.73	0.6
Wisconsin	.008	1.97	0.4

E2 Utilization of newspaper, radio or television or both to increase understanding and knowledge about dental health.

E3 Utilization of films, filmstrips, exhibits and other visual aids to increase understanding and knowledge about dental health.

E6 Preparation and promotion of special dental health "study courses" for PTA or other community groups.

E8 Preparation of education materials for school and classroom.

E9 Organized training of teachers through workshops, seminars, conferences, and so on.

RESEARCH AND STUDY PROJECTS

F1 Surveys to establish the nature and extent of dental diseases and conditions:
—dental caries.

F3 Surveys to establish the nature and extent of dental diseases and conditions:
—malocclusion.

Table 2 • Percentage of States in which there is no activity or inadequate activity in the selected program areas

Program area*	United States	Region			
		Northeast	North Central	South	West
A. Program administration	89	72	87	97	93
B. Preventive, diagnostic and corrective services	98	88	98	100	100
C. Program promotion and consultative services	99	94	98	100	100
D. Public health training and teaching	95	83	98	99	93
E. Dental health education and information	97	81	100	100	100
F. Research and study projects	97	91	100	99	95
Grand total	96	85	97	99	97

*Based on 33 selected program activities.

F5 Surveys to establish the nature and extent of dental diseases and conditions:
—oral cancer.

F9 Surveys to establish total needs of special groups:
—preschool children.

F13 Surveys to establish total needs of special groups:
—the handicapped.

F20 Program evaluation by surveys or other measures for determining the effectiveness or accomplishments of referral programs.

FINDINGS

The figures in Table 1 pose a question. The per cent of all health expenditures budgeted by state health departments for dental health programs in the United States is currently (1958-59) 0.9. By states, this percentage ranges from 5.6 in one sparsely populated area down to 0.1 in two heavily populated areas. Moreover, the per capita expenditure for all

Table 3 • Percentage of States that would initiate or expand program activities in the first year

Program area*	United States	Region			
		Northeast	North Central	South	West
A. Program administration	65	54	57	70	75
B. Preventive, diagnostic and corrective services	48	48	32	54	57
C. Program promotion and consultative services	67	60	68	61	78
D. Public health training and teaching	54	41	50	63	55
E. Dental health education and information	69	52	65	74	78
F. Research and study projects	49	48	47	57	42
Grand total	59	51	53	63	64

*Based on 33 selected program activities.

Table 4 • Percentage of States that would initiate or expand program activities in second to fifth year

Program area*	United States	Region			
		Northeast	North Central	South	West
A. Program administration	18	4	29	23	10
B. Preventive, diagnostic and corrective services	27	14	26	31	32
C. Program promotion and consultative services	21	8	18	30	20
D. Public health training and teaching	31	22	38	29	33
E. Dental health education and information	24	14	33	24	20
F. Research and study projects	39	24	46	36	47
Grand total	27	14	32	29	27

*Based on 33 selected program activities.

public health programs is two and a half times as much in the latter geographical areas. In the opinion of the Council, it would be reasonable to expect the percentage of total health expenditures made for dental health programs to run about the same, regardless of area; it would be reasonable to expect also that with the availability of increased funds, the percentage would remain approximately the same.

If funds were available, initiation or expansion of all program activities would be undertaken during the first year in 59 per cent of all states, with the percentage increasing to 86 per cent in the second to fifth year (Tables 3 and 4). Addition of percentages in the two tables shows also that 93 per cent of the states would expand "Dental Health Education and Information Programs," thus giving the greatest emphasis to this area. Least emphasis (75 per cent of states) would be given to expansion of "Preventive, Diagnostic and Corrective Services," an observation that should not be surprising since more than half the people presently employed and more than half the funds presently expended are devoted to this program area.

The Northeast and South regions presently employ, on the average, 16 to 17 persons per state as compared with 5 to 6 in North Central and West regions. There is an average expenditure in thousands of \$145 by state in the Northeast region, \$130 in the South and \$45 and \$55, respectively, in the West and North Central regions. Analysis of personnel and budget data may demonstrate that the areas that are obviously deficient will still be below par at the end of the five-year period.

Findings for the six program areas will be reported individually, together with general comment on the survey, in Part 2.

1. American Dental Association. Transactions 1958, p. 101.

2. American Dental Association. Council on Dental Health. The state council on dental health program and the support available from the Association. J.A.D.A. 55:112 July 1957.

3. American Dental Association. Transactions 1951, p. 192.

4. American Dental Association. Transactions 1952, p. 35.

5. Conway, Bernard J. Federal grants-in-aid earmarked for state dental public health activities. Presented before 11th National Dental Health Conference, April 25, 1960, American Dental Association, Ambassador West Hotel, Chicago. (Scheduled for publication in J.A.D.A.)

6. American Dental Association. Transactions 1956, p. 203.

Survey of state dental health programs: Part 2

COUNCIL ON DENTAL HEALTH

In the following paragraphs, findings for the six dental health program areas are reported individually. It should be noted that references to the number of personnel involved represent "man-years." One man-year is equal to 2,000 hours, or 50 weeks of employment per year; therefore, each full-time employee is considered to contribute 1.0 man-years to the programs. Personnel employed for a limited time (part time, such as private dentists on a fee-per-hour basis, or full time for only a prescribed portion of the year) are indicated by the appropriate portion of man-years. For example, 100 private dentists contributing 50 hours per year apiece (5,000 hours) would be equivalent to 2.5 man-years; five recent dental graduates employed for approximately 10 weeks each, 1.0 man-years.

DENTAL HEALTH PROGRAM AREAS

Program Administration (Tables 5A-5E). Another title for program administration might well be "National Showcase of Dental Public Health Programs." It embraces (A4) the compilation of program statistics that demonstrate to the public-at-large and legislative bodies, in particular, the effectiveness of such programs and that provide the basis for future planning; (A1) liaison and cooperation in dental health matters with other services and units within the state health agency—for example, nutrition, engineer-

ing, statistics and so on; (A2) liaison and cooperation in dental health matters with other official and voluntary organizations and agencies outside of the state health agency—for example, dental, medical, education and welfare organizations, Parent-Teacher associations and other community and civic groups—in accordance with the concept that dental health is an integral part of total health; (A3) determination of and publicity regarding private practice opportunities in low economic and isolated areas.

Of these four vital areas, (A4) "program statistics" is the activity deemed most inadequate by all states and would receive emphasis from 84 per cent of all states in the first year, with all regions being equally active in its promotion. In view of the proposed appeal to both state and federal legislative bodies for increased appropriations for dental public health activities, the emphasis on "program statistics" is basic. However, in the West, even greater emphasis would be given to (A1 and A2) "liaison within and without state health agencies."

Another activity that demands action is (A3) "finding private practice opportunities." The Council is receiving an increasing number of appeals from communities looking for dentists and from dentists looking for locations. Since the primary objective of all dental public health programs is to improve the dental health of the public, the profession must

Table 5A • Program administration: Percentage of states in which there is no activity or inadequate activity among the selected program areas

Program activity	United States	Region			
		Northeast	North Central	South	West
A1. Liaison within state health agency	77	29	82	87	90
A2. Liaison outside state health agency	91	57	91	100	100
A3. Finding private practice opportunities	93	100	82	100	90
A4. Program statistics	95	100	91	100	90
Total	89	72	87	97	93

Table 5B • Program administration: Percentage of states that would initiate or expand program activities in the first year

Program activity	United States	Region			
		Northeast	North Central	South	West
A1. Liaison within state health agency	65	29	54	73	90
A2. Liaison outside state health agency	67	57	64	60	90
A3. Finding private practice opportunities	44	43	27	60	40
A4. Program statistics	84	86	82	87	80
Total	65	54	57	70	75

Table 5C • Program administration: Percentage of states that would initiate or expand activities in second to fifth year

Program activity	United States	Region			
		Northeast	North Central	South	West
A1. Liaison within state health agency	9	—	27	7	—
A2. Liaison outside state health agency	21	—	27	33	10
A3. Finding private practice opportunities	33	—	54	40	20
A4. Program statistics	11	14	9	12	10
Total	18	4	29	23	10

Table 5D • Program administration: Present personnel and expected expansion by first and fifth years

Personnel	Regions									
	United States		Northeast		North Central		South		West	
	Number of persons	Ratio to present personnel	Number of persons	Ratio to present personnel	Number of persons	Ratio to present personnel	Number of persons	Ratio to present personnel	Number of persons	Ratio to present personnel
Present personnel	100.9	1	21.0	1	20.6	1	40.6	1	18.7	1
Probable personnel need:										
First year	210.2	2.1	30.0	1.4	52.9	2.6	90.9	2.2	36.4	1.9
Fifth year	362.0	3.6	30.0	1.4	75.8	3.7	193.1	4.8	66.1	3.5

Table 5E • Program administration: Present budget and expected budgetary needs by first and fifth years

Budget	Regions									
	United States		Northeast		North Central		South		West	
	Amount in thousands	Ratio to present budget	Amount in thousands	Ratio to present budget	Amount in thousands	Ratio to present budget	Amount in thousands	Ratio to present budget	Amount in thousands	Ratio to present budget
Present budget	\$ 779	1	\$ 136	1	\$ 161	1	\$ 315	1	\$ 167	1
Probable budget need:										
First year	1,699	2.4	249	1.8	430	2.7	696	2.2	524	3.1
Fifth year	2,875	3.7	249	1.8	585	3.6	1,370	4.3	671	4.0

Table 6A • Preventive, diagnostic, and corrective services: Percentage of states in which there is no activity or inadequate activity among the selected program areas

Program activity	United States	Region			
		Northeast	North Central	South	West
B3. Promotion of fluoridation	91	57	91	100	100
B10. Provide referral programs	98	86	100	100	100
B12. Treatment for indigent elementary school children	98	86	100	100	100
B16. Treatment for homebound	100	100	100	100	100
B17. Treatment for those in nursing homes	100	100	100	100	100
B26. Treatment for other physically handicapped	100	100	100	100	100
Total	98	88	98	100	100

see that required dental care is available. It has found that its objective of providing the highest quality of care to the greatest number of people can be fulfilled best through the facilities of private practice.⁷ The South would devote major effort among the regions to "finding private practice opportunities."

From standpoints of personnel and budget, "Program Administration" is the second largest program area in the United States, and three and one half fold expansion is planned in both personnel and funds, with the largest in the South.

Preventive, Diagnostic and Corrective Services (Tables 6A-6E) • The area, preventive, diagnostic and corrective services, currently tops all others in budget and personnel as was stated earlier. Nonetheless, nearly every state in every region reported inadequate activity for every program in this area. The one exception was in the Northeast where only 57 per cent of the states reported that the "promotion of fluoridation" was inadequate.

Although fewer states may give major

emphasis to expansion in this area, the proposed activities will require the greatest increase in both funds and personnel: from \$2,058,000 to \$17,372,000, or 8.4 times the present budget; from 270.5 persons to 1,723.9, or 6.4 times the number of present personnel. On a regional basis, the number of personnel will be increased nearly 12 times in the North Central, nearly 11 times in the West. In the South, the number of personnel will be increased nearly seven times; in the Northeast, nearly three times.

The activity that would receive greatest emphasis in this area the first year is "promotion of fluoridation." If such promotion led to the fluoridation of every eligible public water supply in the U.S., it is estimated that the cost would be approximately 12 million dollars annually with expected annual savings of 680 million dollars as a result of dental treatment made unnecessary by the preventive procedure. Said another way, there could be a savings of \$56 for every dollar expended.⁸ In those areas where fluoridation is not feasible, economic as well as personal health benefits could be reaped by the extension of topical fluoride appli-

Table 6B • Preventive, diagnostic, and corrective services: Percentage of states that would initiate or expand program activities in the first year

Program activity	United States	Region			
		Northeast	North Central	South	West
B3. Promotion of fluoridation	72	43	73	73	90
B10. Provide referral programs	57	71	18	67	80
B12. Treatment for indigent elementary school children	70	43	64	93	60
B16. Treatment for homebound	28	29	9	33	40
B17. Treatment for those in nursing homes	26	29	9	33	30
B26. Treatment for other physically handicapped	35	71	18	26	40
Total	48	48	32	54	57

Table 6C • Preventive, diagnostic, and corrective services: Percentage of states that would initiate or expand activities in second to fifth year

Program activity	United States	Region			
		Northeast	North Central	South	West
B3. Promotion of fluoridation	7	14	—	7	10
B10. Provide referral programs	14	—	9	20	20
B12. Treatment for indigent elementary school children	9	—	9	7	20
B16. Treatment for homebound	44	29	54	47	40
B17. Treatment for those in nursing homes	49	29	54	47	60
B26. Treatment for other physically handicapped	40	14	27	60	40
Total	27	14	26	31	32

cation programs. In the South, slightly greater emphasis would be given to "treatment for indigent elementary school children" the first year, whereas the Northeast would concentrate more on "referral programs" and "treatment for the physically handicapped" in this period.

Three program activities would receive

considerable emphasis in the second to fifth years: "treatment for homebound," "for those in nursing homes" and "for other physically handicapped." In view of the fact that members of these segments of the population cannot go to the dental office, the problem of obtaining the dental care which is needed for them is accentuated.

Table 6D • Preventive, diagnostic, and corrective services: Present personnel and expected expansion by first and fifth years

Personnel	United States		Regions							
			Northeast		North Central		South		West	
	Number of persons	Ratio to present personnel	Number of persons	Ratio to present personnel	Number of persons	Ratio to present personnel	Number of persons	Ratio to present personnel	Number of persons	Ratio to present personnel
Present personnel	270.5	1	65.5	1	26.9	1	165.3	1	12.8	1
Probable personnel need:										
First year	788.8	2.9	128.0	2.0	100.1	3.7	490.7	3.0	70.0	5.5
Fifth year	1,723.9	6.4	182.5	2.8	312.3	11.6	1,091.2	6.6	137.9	10.8

Table 6E • Preventive, diagnostic, and corrective services: Present budget and expected budgetary needs by first and fifth years

Budget	United States		Regions							
			Northeast		North Central		South		West	
	Amount in thousands	Ratio to present budget	Amount in thousands	Ratio to present budget	Amount in thousands	Ratio to present budget	Amount in thousands	Ratio to present budget	Amount in thousands	Ratio to present budget
Present budget	\$2,058	1	\$ 694	1	\$ 170	1	\$1,080	1	\$ 114	1
Probable budget need:										
First year	9,128	4.4	1,162	1.7	1,581	9.3	4,019	3.7	2,366	20.8
Fifth year	17,372	8.4	1,570	2.3	3,300	19.4	9,154	8.5	3,348	29.4

Table 7A • Program promotion and consultative services: Percentage of states in which there is no activity or inadequate activity among the selected program areas

Program activity	United States	Region			
		Northeast	North Central	South	West
C1. Consultation to local dental programs	98	86	100	100	100
C2. Financing employment of dental personnel	98	86	100	100	100
C4. Financing preventive programs	100	100	100	100	100
C5. Financing educational programs	100	100	100	100	100
C6. Financing other local programs	98	100	91	100	100
Total	99	94	98	100	100

Program Promotion and Consultative Services (Tables 7A-7E) • This area, program promotion and consultative services, presents the least evidence of activity, with 99 per cent of all states reporting complete absence or inadequacy. The reason may be found in the refrain that occurs in the titles of the various activities listed in this program area: "financing."

The need for such activities is supported by the fact that expansion is planned by 67 per cent of the states in

the first year. With regard to budget, the Northeast and North Central regions would expend the second largest amount in this area in both the first year and the second to fifth years; the West, its third greatest expenditure in both periods; the South, its fourth greatest expenditure the first year, and its fifth greatest in the second to fifth years. In the West, the expansion in personnel would have the same status as that in budget; in the South it would be the same the first year,

Table 7B • Program promotion and consultative services: Percentage of states that would initiate or expand program activities in the first year

Program activity	United States	Region			
		Northeast	North Central	South	West
C1. Consultation to local dental programs	74	71	73	73	80
C2. Financing employment of dental personnel	60	43	64	53	80
C4. Financing preventive programs	74	71	82	67	80
C5. Financing educational programs	79	71	100	67	80
C6. Financing other local programs	47	43	27	47	70
Total	67	60	68	61	78

Table 7C • Program promotion and consultative services: Percentage of states that would initiate or expand activities in second to fifth year

Program activity	United States	Region			
		Northeast	North Central	South	West
C1. Consultation to local dental programs	16	14	18	12	20
C2. Financing employment of dental personnel	23	—	18	40	20
C4. Financing preventive programs	21	14	18	26	20
C5. Financing educational programs	16	14	—	26	20
C6. Financing other local programs	30	—	36	47	20
Total	21	8	18	30	20

moving up to fourth place in the fifth year; in the Northeast, it would go to third in the first year and back up to second in the fifth year; in the North Central, it would go to fourth for both periods.

The need of the health professions and community agencies for consultation in the development of any health program that is to be effective is obvious. Once the goals that can be attained have been established—health and socioeconomic—the need for their promotion in the community is, likewise, obvious. Meeting the needs of the chronically ill and aged provides an excellent example of activities that need to be undertaken in the way of planning, promotion and consultation as outlined in a previous Council report:⁹

(1) the planning and conducting of studies to evaluate the dental health of patients in the various chronic disease facilities (this should be a cooperative endeavor of the community public health agency and the component dental society so that the skills of both can be utilized); (2) assessment of total community resources for care of the chronically ill and efforts to include dentists on the appropriate boards where possible; (3) the education of all persons involved in community health resources concerning the dental problems of the chronically ill; (4) the establishment of a loan closet of portable dental equipment by the

appropriate health agency so that dentists can begin to meet the dental health needs of the chronically ill and handicapped patient; (5) the establishment of an official dental committee which would act as a clearinghouse of information, educational material, and would help in developing programs concerned with the chronically ill and disabled; (6) a study to explore methods of financing dental services for the chronically ill and handicapped; (7) the development of projects to demonstrate new and better ways of providing dental service to the chronically ill and disabled.

Public Health Training and Teaching (Tables 8A-8E) • The smallest number of persons (11.6) is devoted to the public health training and teaching program area as is the smallest budget, and although there is slightly more activity among certain specific programs within the area, 95 per cent of all the states indicate that it is inadequate or nonexistent. With regard to “workshops for private nurses” and “teaching of dental health in teacher training schools,” 100 per cent of the states report inadequacy or absence of activity, while the same situation is reported in all regions but the South in the “provision of externships.”

In the North Central and West regions, the highest percentage of states will emphasize “inservice training to dental staff” during the first year, although the

Table 7D • Program promotion and consultative services: Present personnel and expected expansion by first and fifth years

Personnel	Regions											
	United States		Northeast			North Central		South		West		
	Number of persons	Ratio to present personnel	Number of persons	Ratio to present personnel	Ratio to present personnel	Number of persons	Ratio to present personnel	Number of persons	Ratio to present personnel	Number of persons	Ratio to present personnel	
Present personnel	39.3	1	15.4	1		6.4	1	12.1	1	5.4	1	
Probable personnel need:												
First year	113.1	2.9	21.8	1.4		23.0	3.6	46.9	3.9	21.4	4.0	
Fifth year	223.7	5.7	31.4	2.0		38.7	6.0	109.2	9.0	44.4	8.2	

Table 7E • Program promotion and consultative services: Present budget and expected budgetary needs by first and fifth years

Budget	United States						Regions												
	Amount in thousands		Ratio to present budget		Northeast		North Central		South		West								
					Amount in thousands	Ratio to present budget	Amount in thousands	Ratio to present budget	Amount in thousands	Ratio to present budget	Amount in thousands	Ratio to present budget							
Present budget	\$ 331		1		\$ 110		1		\$ 66		1		\$ 105		1		\$ 50		1
Probable budget need:																			
First year	1,558		4.7		435		4.0		494		7.5		417		4.0		212		4.2
Fifth year	2,524		7.6		520		4.7		639		9.7		943		9.0		422		8.4

Table 8A • Public health training and teaching: Percentage of states in which there is no activity or inadequate activity among the selected program areas

Program activity	United States	Region			
		Northeast	North Central	South	West
D1. Inservice training to dental staff	91	71	100	93	90
D7. Workshops for private nurses	100	100	100	100	100
D8. Sponsor short university courses	95	86	91	100	100
D11. Provide externships	98	100	100	100	90
D12. Provide job orientation	86	43	100	100	80
D13. Teach dental health in teacher training schools	100	100	100	100	100
Total	95	83	98	99	93

majority of southern states will give priority to "providing job orientation" and more of the Northeastern states to "sponsoring short university courses." By the fifth year, "teaching of dental health in teacher training schools" will be expanded in 100 per cent of the North Central and Western states; "sponsorship of short university courses" in 100 per cent of the Southern states and 86 per cent of the Northeastern states; "provision of job orientation" in 100 per cent

of the North Central states; "workshops for private nurses" in 100 per cent of the Western states.

With the existing shortage of dental manpower—dental personnel in general and public health personnel—it is obvious that recruitment and promotion of training activities should have high priority among dental public health programs. Such programs will need to include recruitment and promotion of training activities for dental hygienists, dental assist-

Table 8B • Public health training and teaching: Percentage of states that would initiate or expand program activities in the first year

Program activity	United States	Region			
		Northeast	North Central	South	West
D1. Inservice training to dental staff	63	29	73	67	70
D7. Workshops for private nurses	51	43	54	40	60
D8. Sponsor short university courses	51	57	45	53	50
D11. Provide externships	32	29	—	53	40
D12. Provide job orientation	65	43	64	87	60
D13. Teach dental health in teacher training schools	63	43	64	80	50
Total	54	41	50	63	55

Table 8C • Public health training and teaching: Percentage of states that would initiate or expand activities in second to fifth year

Program activity	United States	Region			
		Northeast	North Central	South	West
D1. Inservice training to dental staff	19	29	9	26	10
D7. Workshops for private nurses	40	29	36	47	40
D8. Sponsor short university courses	40	29	36	47	40
D11. Provide externships	44	14	73	33	50
D12. Provide job orientation	14	—	36	7	10
D13. Teach dental health in teacher training schools	30	29	36	12	50
Total	31	22	38	29	33

ants and dental laboratory technicians as well as training programs for their effective utilization.

Dental Health Education and Information (Tables 9A-9E) • In view of the importance given to dental health education by the American Dental Association, which has a Bureau to handle this one activity at the national level; by state and local dental societies which have committees—and, in many instances, employed personnel—devoted to this activity; by state health departments which spend thousands of dollars on the distribution of information materials alone, to say nothing of the efforts of their personnel in working with dental societies and other community agencies and state education departments to raise the public's level of dental health education, the percentages shown in Table 9A must be interpreted as reflecting inadequacy and not inactivity. In both budget and personnel, this program area ranks third in the North Central, South and West; fourth, in the Northeast.

"Information of the public" would receive maximum attention in this program area during the first year, with 91 per cent of all states planning expansion;

following as close seconds would be "increasing public understanding" and "utilization of visual aids."

The other three activities in this area—"preparation of study courses for community groups," "preparation of education material for classroom use" and "training of teachers in workshops"—would require more preparation; hence, their somewhat substantial expansion in the second to fifth year. To achieve the proposed expansion will require an average increase of some six times the present budget and the present number of personnel.

One of the dental profession's greatest single efforts to educate the public to the benefits of dental health is the annual National Children's Dental Health Week, for which the Association's 1960 budget is \$15,000. This amount is augmented by state and local dental societies which develop their own observance at the community level with the guidance of the Association and its promotion of the event at the national level. It might be pointed out that the objective of this project is not a "once a year" promotion for publicity purposes but a device for initiating sound, effective programs, the results of which are additive.

Table 8D • Public health training and teaching: Present personnel and expected expansion by first and fifth years

Personnel	Regions										
	United States		Northeast		North Central		South		West		
	Number of persons	Ratio to present personnel	Number of persons	Ratio to present personnel	Number of persons	Ratio to present personnel	Number of persons	Ratio to present personnel	Number of persons	Ratio to present personnel	
Present personnel	11.6	1	1.2	1	4.3	1	4.0	1	2.1	1	
Probable personnel need:											
First year	57.3	4.9	2.8	2.3	15.1	3.5	31.7	7.9	7.7	3.7	
Fifth year	88.5	7.6	3.1	2.6	20.5	4.8	49.2	12.3	15.7	7.5	

Table 8E • Public health training and teaching: Present budget and expected budgetary needs by first and fifth years

Budget	Regions									
	United States		Northeast		North Central		South		West	
	Amount in thousands	Ratio to present budget	Amount in thousands	Ratio to present budget	Amount in thousands	Ratio to present budget	Amount in thousands	Ratio to present budget	Amount in thousands	Ratio to present budget
Present budget	\$ 161	1	\$26	1	\$ 67	1	\$ 39	1	\$ 29	1
Probable budget need:										
First year	747	4.6	57	2.2	241	3.6	347	8.9	102	3.5
Fifth year	1,283	8.0	77	3.0	402	6.0	610	15.6	194	6.7

Table 9A • Dental health education and information: Percentage of states in which there is no activity or inadequate activity among the selected program areas

Program activity	United States	Region			
		Northeast	North Central	South	West
E1. Inform public	98	86	100	100	100
E2. Increase public understanding	98	86	100	100	100
E3. Utilize visual aids	93	57	100	100	100
E6. Prepare study courses for community groups	98	86	100	100	100
E8. Prepare education material for classroom use	98	86	100	100	100
E9. Train teachers in workshops	98	86	100	100	100
Total	97	81	100	100	100

Research and Study Projects (Tables 10A-10E) • The relation of the research and study projects area to other program areas adds to its importance, since it is the logical first link in a chain reaction: needs must be determined before effective programs can be designed. The inadequacy of activity ranges from 100 per cent in all program activities in 100 per cent of all states in the Northeast region to 100 per cent in three program activities in 100 per cent of all states in all regions: “malocclusion surveys,” “oral cancer sur-

veys” and “surveys of the handicapped.”

Among specific needs in this area that are not now being satisfied by state and local support is the maintenance of up-to-date statistics on the dental needs of the population-at-large as well as its various segments—persons living in rural areas, the indigent, the institutionalized, the homebound and so on—and of up-to-date statistics on the availability of dental care to meet the needs.

Seventy-two per cent of all states would initiate or expand “dental caries surveys”

Table 9B • Dental health education and information: Percentage of states that would initiate or expand program activities in the first year

Program activity	United States	Region			
		Northeast	North Central	South	West
E1. Inform public	91	71	100	93	90
E2. Increase public understanding	81	57	82	87	90
E3. Utilize visual aids	84	57	91	93	80
E6. Prepare study courses for community groups	42	29	27	40	70
E8. Prepare education material for classroom use	65	43	54	80	70
E9. Train teachers in workshops	53	57	36	53	70
Total	69	52	65	74	78

Table 9C • Dental health education and information: Percentage of states that would initiate or expand in second to fifth year

Program activity	United States	Region			
		Northeast	North Central	South	West
E1. Inform public	5	—	—	7	10
E2. Increase public understanding	12	14	18	7	10
E3. Utilize visual aids	7	—	9	7	10
E6. Prepare study courses for community groups	47	29	64	53	30
E8. Prepare education material for classroom use	30	29	45	20	30
E9. Train teachers in workshops	42	14	64	47	30
Total	24	14	33	24	20

the first year, with 87 per cent of the Southern and 70 per cent of the Western states giving primary attention to this activity. In the North Central region, 91 per cent of the states would emphasize "evaluation of referral programs" during this period.

More activity would be postponed to the second to fifth year in this program area than in any of the other five program areas. By the fifth year, 100 per cent of all states would have initiated or expanded "malocclusion surveys"; 89 per cent of all states, "surveys of preschool children"; 88 per cent of all states, "dental caries surveys" and "evaluation of referral programs"; 84 per cent of all states, "surveys of the handicapped"; 81 per cent of all states, "oral cancer surveys."

The small number of persons reported to be engaged in "Research and Study Projects" throughout the United States (20.4) calls for an explanation and a distinction. As stated earlier in this report, "total personnel" refers to "man-years" and not individuals. Some public health personnel are engaged in various research activities all or only a part of their employed time, and some persons are employed on a part-time basis, but the total time of all such individuals is equivalent to that of 20.4 full-time persons.

A distinction should be made between the foregoing type of research which is concerned with improving the effectiveness of dental public health programs, in particular, and basic biological research which is concerned with understanding the nature of dental health and disease, in general, and developing methods for improving the health and preventing the disease. The Commission on the Survey of Dentistry in the United States will report that some 1,300 investigators¹⁰—ranging from dentists to technicians—are engaged in the latter area at the National Institute of Dental Research, dental schools and other institutions through funds made available from the federal government, universities, philanthropic foundations, industry, alumni associations, individual contributions and so on.

Among basic needs in the area of research are the improvement of epidemiological methods and the development of tools to measure such important diseases as periodontal impairments and dental facial handicaps. Another research area that calls for considerable attention is "administrative research"—extensive study should be made with regard to the planning, operation and evaluation of present dental public health programs in order to improve their effectiveness.

Table 9D • Dental health education and information: Present personnel and expected expansion by first and fifth years

Personnel	United States		Regions							
			Northeast		North Central		South		West	
	Number of persons	Ratio to present personnel	Number of persons	Ratio to present personnel	Number of persons	Ratio to present personnel	Number of persons	Ratio to present personnel	Number of persons	Ratio to present personnel
Present personnel	38.3	1	2.9	1	6.6	1	23.3	1	5.5	1
Probable personnel need:										
First year	137.0	3.6	9.6	3.3	38.0	5.8	75.3	3.2	14.1	2.6
Fifth year	247.0	6.4	17.6	6.1	52.0	7.9	147.0	6.3	30.4	5.5

Table 9E • Dental health education and information: Present budget and expected budgetary needs by first and fifth years

Budget	United States		Regions							
			Northeast		North Central		South		West	
	Amount in thousands	Ratio to present budget	Amount in thousands	Ratio to present budget	Amount in thousands	Ratio to present budget	Amount in thousands	Ratio to present budget	Amount in thousands	Ratio to present budget
Present budget	\$ 364	1	\$ 38	1	\$ 81	1	\$ 193	1	\$ 52	1
Probable budget need:										
First year	1,347	3.7	76	2.0	448	5.5	674	3.5	149	2.9
Fifth year	2,283	6.3	125	3.3	604	7.5	1,267	6.6	287	5.5

Table 10A • Research and study projects: Percentage of states in which there is no activity or inadequate activity among the selected program areas

Program activity	United States	Region			
		Northeast	North Central	South	West
F1. Dental caries surveys	91	86	100	93	80
F3. Malocclusion surveys	100	100	100	100	100
F5. Oral cancer surveys	100	100	100	100	100
F9. Surveys of preschool children	95	71	100	100	100
F13. Surveys of the handicapped	100	100	100	100	100
F20. Evaluation of referral programs	95	86	100	100	90
Total	97	91	100	99	95

Table 10B • Research and study projects: Percentage of states that would initiate or expand program activities in the first year

Program activity	United States	Region			
		Northeast	North Central	South	West
F1. Dental caries surveys	72	57	64	87	70
F3. Malocclusion surveys	37	43	27	40	40
F5. Oral cancer surveys	23	14	18	33	20
F9. Surveys of preschool children	63	71	64	67	50
F13. Surveys of the handicapped	35	43	18	53	20
F20. Evaluation of referral programs	65	57	91	60	50
Total	49	48	47	57	42

Table 10C • Research and study projects: Percentage of states that would initiate or expand activities in second to fifth year

Program activity	United States	Region			
		Northeast	North Central	South	West
F1. Dental caries surveys	16	29	27	7	10
F3. Malocclusion surveys	63	57	73	60	60
F5. Oral cancer surveys	58	29	73	60	60
F9. Surveys of preschool children	26	—	27	26	40
F13. Surveys of the handicapped	49	29	64	33	70
F20. Evaluation of referral programs	23	—	9	33	40
Total	39	24	46	36	47

Table 10D • Research and study projects: Present personnel and expected expansion by first and fifth years

Personnel	Regions									
	United States		Northeast		North Central		South		West	
	Number of persons	Ratio to present personnel	Number of persons	Ratio to present personnel	Number of persons	Ratio to present personnel	Number of persons	Ratio to present personnel	Number of persons	Ratio to present personnel
Present personnel	20.4	1	2.6	1	4.5	1	10.5	1	2.8	1
Probable personnel need:										
First year	78.7	3.9	6.8	2.6	22.6	5.0	35.5	3.4	13.8	4.9
Fifth year	163.1	8.0	10.4	4.0	36.8	8.2	88.3	8.4	27.6	9.9

Table 10E • Research and study projects: Present budget and expected budgetary needs by first and fifth years

Budget	Regions									
	United States		Northeast		North Central		South		West	
	Amount in thousands	Ratio to present budget	Amount in thousands	Ratio to present budget	Amount in thousands	Ratio to present budget	Amount in thousands	Ratio to present budget	Amount in thousands	Ratio to present budget
Present budget	\$ 185	1	\$ 20	1	\$ 46	1	\$ 92	1	\$ 27	1
Probable budget need:										
First year	837	4.5	79	3.9	220	4.8	404	4.4	134	5.0
Fifth year	1,679	9.1	113	5.6	351	7.6	952	10.3	263	9.7

COMMENT

Nearly every state in the union has evaluated its dental public health programs through the joint effort of the state dental division and the state dental society. The evaluation has been accomplished through the completion of a questionnaire "State Dental Division Program Survey and Cost Estimate Form" developed by the Council on Dental Health in cooperation with the American Association of Public Health Dentists.

The findings show inadequacy in current dental health program activities, a parallel inadequacy in the amount of available funds. They show the programs that could be undertaken to bring about lasting benefits in the public interest. They show the costs of initiating or expanding such programs. They will be useful to the Association's Council on Legislation in documenting testimony to support a bill (S. 3780) introduced at the request of the Association by Senator Lister Hill (D., Ala.). The bill calls for the establishment of a dental category in the program for federal grants-in-aid to states for general health activities.

Action at the state level must precede such appeal at the federal level. Thus, state dental divisions and state dental societies, which are to be commended for their efforts in accumulating the impressive data for this survey, must work further to obtain support from state legislatures, state health departments and state governors. In addition to presenting to the legislatures the information provided

on the survey forms, they will need to dramatize the statistical data with examples of effective community activities. The state dental society could adopt resolutions showing that it favors federal funds for state dental health activities, specifying the new programs that are needed and existing ones that should be expanded and urging state legislatures to appropriate the funds necessary to conduct the programs the society supports. The activities at the state level should all be coordinated through the state dental society and should have enthusiastic participation from both private practitioners and public health dentists.

When increased funds are made available through state appropriations and matched through the device of a dental category in the federal grant-in-aid program, the public can look forward, confidently, to improved dental health for all segments of the population as a result of the programs that will be made possible. The public will find that "cost" in reference to such programs is a misnomer for "investment" since the returns will be in economic as well as health benefits.

7. American Dental Association, Council on Dental Health, Council program in dental practice. J.A.D.A. 61:118 July 1960.

8. Executive Memorandum of the Bureau of State Services for the Regional Medical Directors, Public Health Service, April 18, 1960.

9. Sheldon, Marvin P. Recent developments concerning dental care for the chronically ill and aged. J.A.D.A. 59:505 Sept. 1959.

10. Dentistry in the United States. Chicago, Survey of Dentistry, summary volume scheduled for publication November 1, 1960.

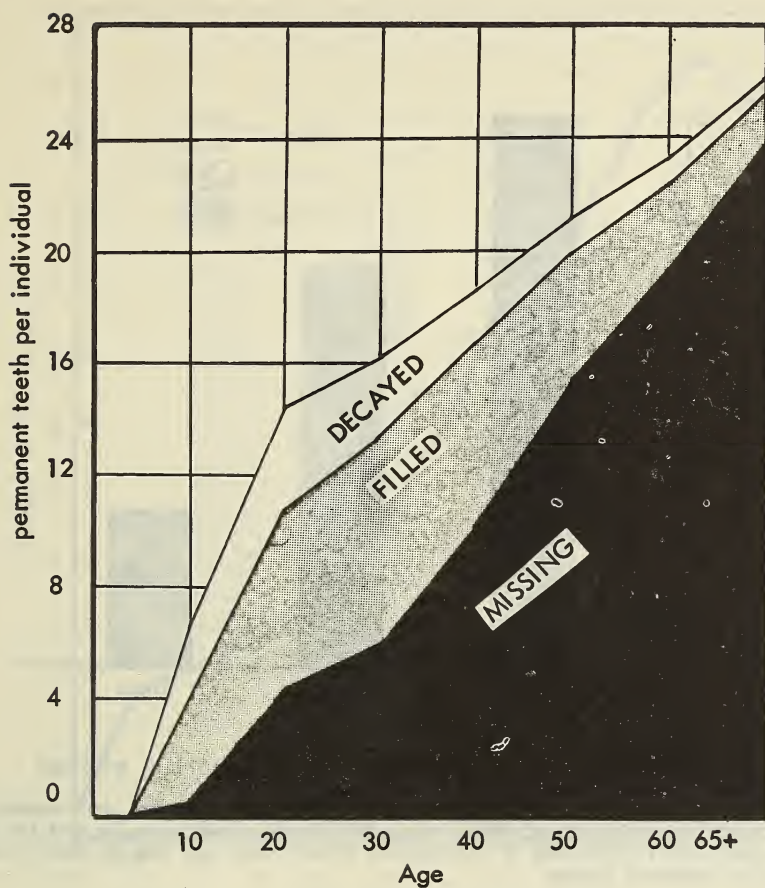
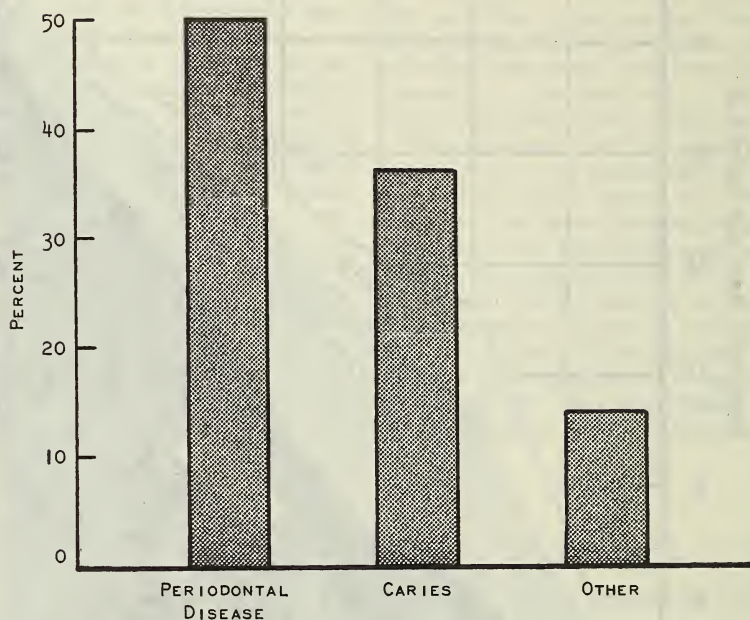


CHART I.—Dental diseases—a lifelong problem.

Before age 20: 14 teeth decayed, filled, or missing.

Before age 40: 18 teeth decayed, filled, or missing.

Before age 60: 23 teeth decayed, filled, or missing.



PERCENTAGE OF TEETH INDICATED FOR EXTRACTION, BY CAUSE

CHART II.—Tooth loss: 23 million people in the United States are completely without natural teeth—3 people in 10 past age 35, 4 people in 10 past age 45, 5 people in 10 past age 55; 86 percent of all tooth loss results from caries and periodontal disease.

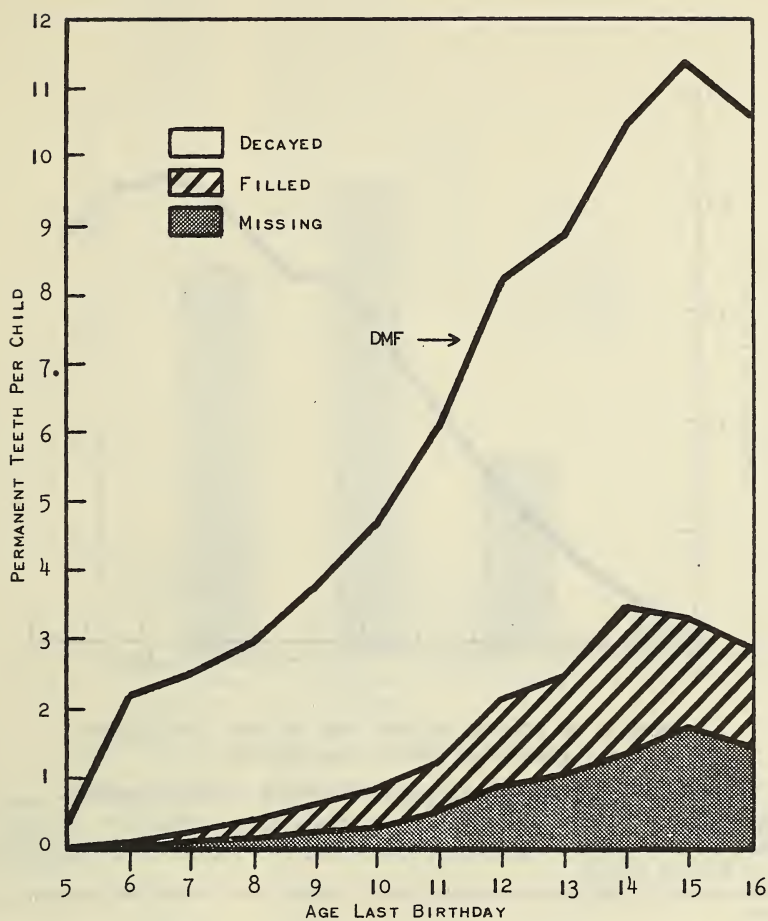
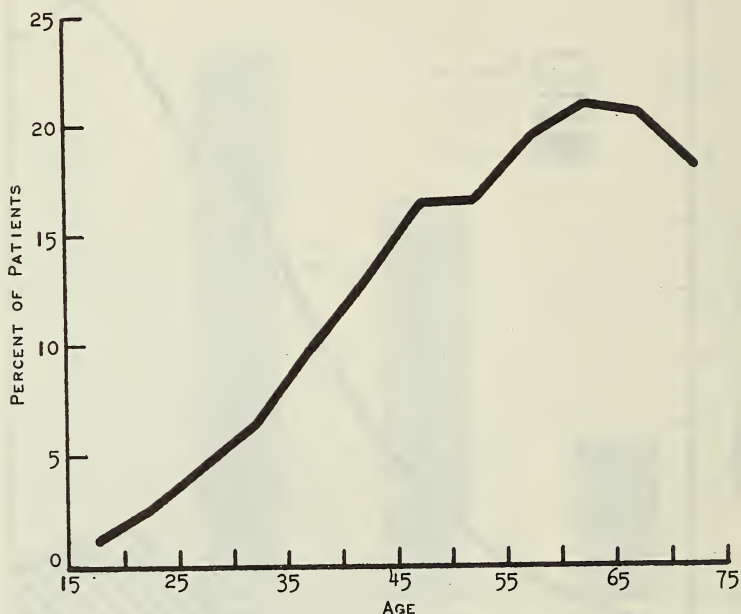


CHART III.—Dental caries: 11 permanent teeth per child are affected by age 15.



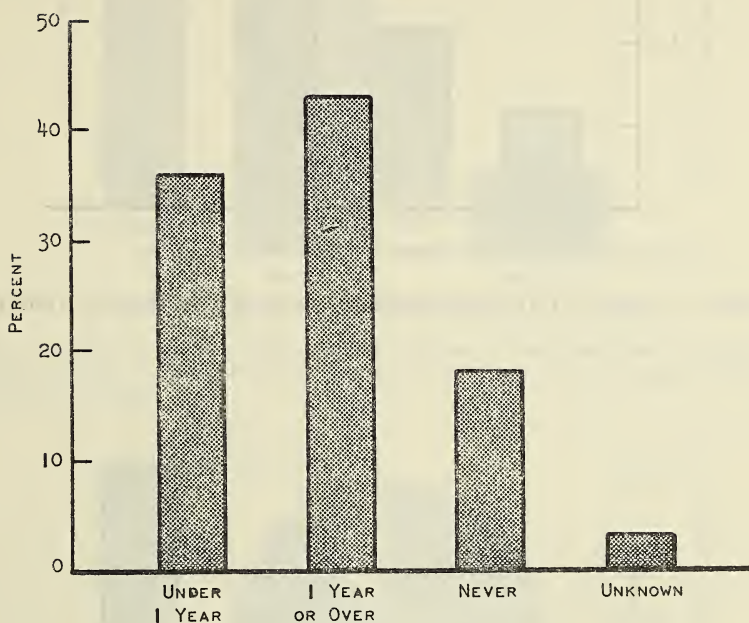
PERCENT OF PERSONS NEEDING ONE OR MORE EXTRACTIONS
BECAUSE OF PERIODONTAL DISEASE

CHART IV.—Periodontal disease—the major problem in adults.

Malocclusion: Affects one-half of all school age children.

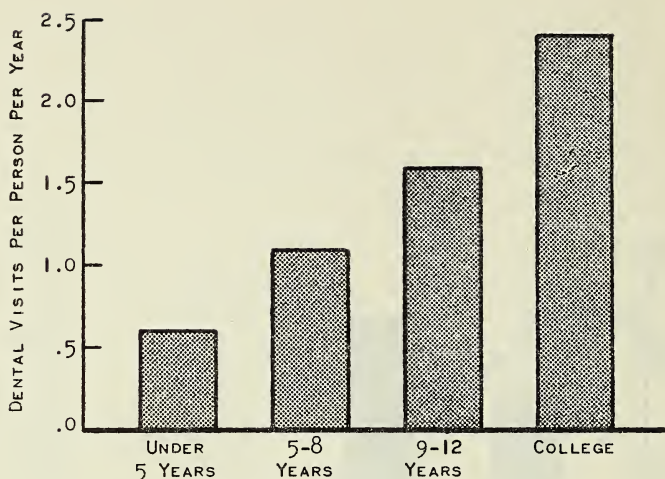
Cleft lip and palate: The second most common congenital anomaly. Occur in 1 in 800 live births.

Oral cancer: 23,000 cases annually, one of forty cancer deaths results from oral cancer.

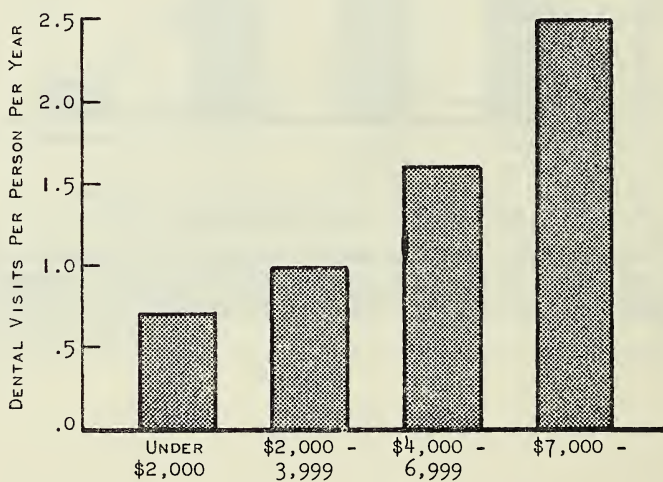


TIME INTERVAL SINCE LAST DENTAL VISIT

CHART V.—Utilization of dental services: Untreated dental diseases progress rapidly and become increasingly complex.—One-fifth of the population has never visited a dentist; less than two-fifths of the population visits a dentist in a year.



NUMBER OF DENTAL VISITS PER PERSON PER YEAR BY EDUCATION OF FAMILY HEAD



NUMBER OF DENTAL VISITS PER PERSON PER YEAR BY FAMILY INCOME

CHART VI.—Persons with little education and low incomes receive less dental care.

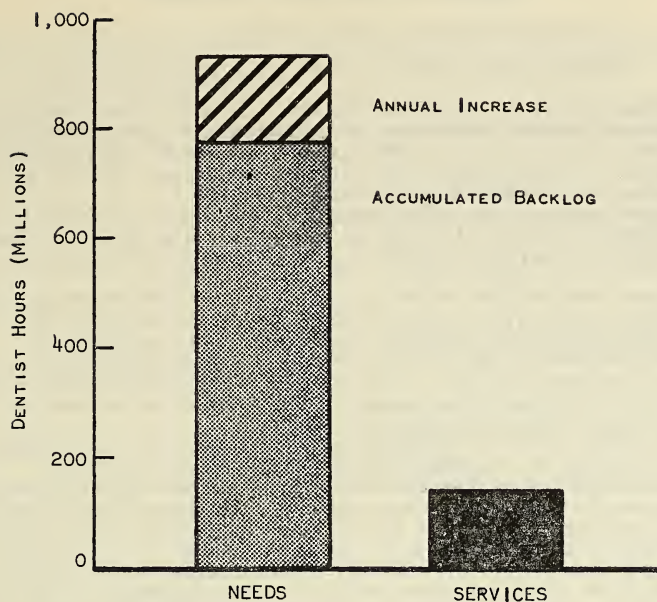
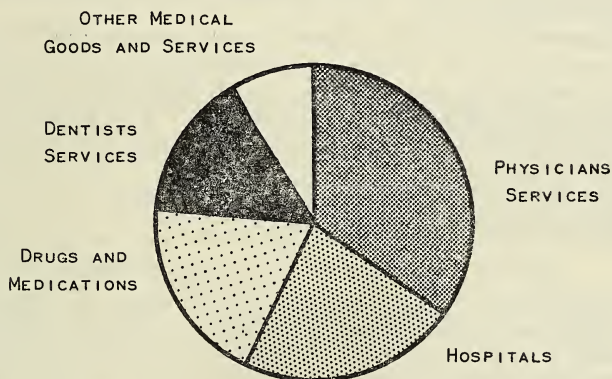


CHART VII.—Disparity between dental needs and services.

The backlog of accumulated dental disease—a backlog that includes 700 million unfilled cavities—is great enough to keep our present dental force employed for 5 years.



COMPOSITION OF THE MEDICAL CARE DOLLAR

CHART VIII.—Costs of dental disease

Consumer expenditures: The Nation's dental bill is \$2.4 billion annually—15 percent of the total health dollar.

Industrial production: Each year about 85 million industrial man-hours are lost through absenteeism attributed to dental disease. The loss in industrial production—approximately \$250 million.

National Defense: 50,000 draftees—the equivalent of 3 military divisions—were rejected in World War II for dental reasons. Each 100 military inductees now need 20 dentures, 25 bridges, 80 extractions, 505 fillings.

[From the Evening Star of Washington, D.C., May 23, 1962]

DENTAL BUREAU TOO POOR TO HELP NEEDY CHILDREN

Dr. A. Harry Ostrow, chief of the District Bureau of Dental Health, has confirmed charges that the Bureau is so underfinanced and understaffed that it fails to treat three out of four of the needy children for whom it is responsible.

The charge was made earlier in an interview in February with Dr. Israel Shulman, president of the District Dental Society.

Dr. Ostrow confirmed the figures yesterday afternoon before the District Public Health Advisory Council. He said the Bureau has been the poor sister of the District Health Department and has never been permitted to share in Federal funds.

In the past year, he said, about 45 percent of the District's school population were eligible for clinic care. But, he continued, three out of four of these went without care because the Bureau is understaffed and underequipped.

He said the Bureau will get seven additional dental assistants in the 1963 budget and that this will help. But because of lack of sympathy for the program in the Health Department, the Bureau has remained static for many years while money has flowed into other programs.

"Other services have had money left that they couldn't spend without making last minute purchases of equipment—and none was shared," he said.

"My impression is that they (the Department and its other bureaus) program in advance so that there is no money left over," Dr. Ostrow said.

Council member Dr. Daniel F. Lynch, himself a dentist, said, "It sounds like the old money game: I've got mine, how are you doing?"

Dr. Israel Shulman, president of the District Dental Society, said the society is alarmed at the "lack of care for underprivileged children."

Dr. Shulman praised Dr. Ostrow's work and said to look to the share of the departmental budget for the cause of the Bureau's problems.

The CHAIRMAN. Let me ask you this, Doctor. You heard Secretary Cohen's testimony. Have you any comment on the alternative approach he suggested for authorizing matching grants for the State departmental programs?

Dr. HILLENBRAND. By administrative actions other than legislation?

The CHAIRMAN. No. It would take legislation, as I understand his proposal, to authorize dental public health grants by amending a provision now in the Public Health Service Act. You might examine the Secretary's proposal and his statement more carefully and let us have the benefit of your views.

Dr. HILLENBRAND. I will submit a statement on it.

(Dr. Hillenbrand's statement follows:)

PREPARED STATEMENT OF DR. HAROLD HILLENBRAND

On the basis of long experience, the American Dental Association does not believe the approach suggested by the Department of Health, Education, and Welfare would be a realistic alternative to the provisions in S. 917 which would establish specific statutory authority for grants-in-aid for dental health activities.

The Department suggests that the purposes of S. 917 could be accomplished under the Community Health Services and Facilities Act if such act is amended to eliminate the present appropriation ceiling.

The association appreciates and commends the Department for its unreserved support of the purposes of S. 917. It is believed, however, that these purposes can best be achieved by enactment of S. 917 leaving intact the provision for specific statutory earmarking.

While the association recognizes that theoretically it is possible to allocate funds for dental programs under the Community Health Services and Facilities Act, the dental profession has had many years of disappointing experience with other laws providing grant authority for general health purposes. For example, in the Department's own testimony to this committee, it was brought out that in 1961, the Public Health Service made general health grants of \$17 million to State public health departments, yet only \$125,000, just 0.7 percent of the total,

was allocated for dental activities. On the basis of this and similar experience over the years, the association believes strongly that specific formula grant authority should be retained in S. 917.

The association also believes it would be desirable to retain in the bill the provision for an advisory committee to assist the Surgeon General in making decisions relative to the approval of project grants.

The CHAIRMAN. We would be happy to have that.

Senator YARBOROUGH. Mr. Chairman, Dr. Hillenbrand didn't use any painkiller with his statement, and I think it it had been physically possible for the entire Congress to have heard it, this bill would be speedily passed and become law.

I congratulate you on this hard-hitting, factual statement, Doctor, and on the matter in which in a few minutes you have demonstrated to me the need for this legislation.

Dr. HILLENBRAND. Thank you, Senator Yarborough.

The CHAIRMAN. We certainly appreciate, as I said, your very fine, enlightening, and persuasive statement, Doctor.

Is there anything the other gentlemen would like to add?

Dr. KENNEDY. No, sir.

The CHAIRMAN. Thank you.

The next witness is Dr. Woodward D. Lamar, Alabama State Dental Association, Montgomery.

Doctor, we are glad to have you and Mr. Russell with us, and we will be happy to have you proceed.

STATEMENT OF WOODWARD D. LAMAR, D.D.S., ALABAMA STATE DENTAL ASSOCIATION, MONTGOMERY, ALA.; ACCOMPANIED BY B. J. RUSSELL

Dr. LAMAR. Thank you, sir.

I would like to start off by stating that nothing which we are going to present will be in exception to what has been presented by Dr. Hillenbrand of the American Dental Association. Our basic purpose is to see as best we can that the program which he points out will be put in very clear terms in the bill, so that there will be no misunderstanding by anyone connected with the administration of the executive execution of the bill.

We feel that the committee is seeking to find an answer to the question: How can the dental health of the community be improved?

We have been bombarded with figures and charts showing every conceivable phase of dental health, the most impressive being the ratio of dental problems to dentists available to treat these problems. Whether all these figures and conclusions drawn from them are accurate is of no consequence. The same problem would have to be faced up to even if there was one cavity in one mouth and there was one available dentist to restore this tooth to a healthy condition.

The problems boil down to:

- (1) How can we prevent the problem from arising?
- (2) How can we convince the individual that his dental problem should have the immediate attention of a dentist?
- (3) If this person is aware that he should seek dental services, can he pay a reasonable fee for it?

The answer to No. 1 lies in preventive dentistry.

The answer to No. 2 is in a patient-education program and a better understanding between the dental profession and the public.

The answer to No. 3 lies in the financial status of the individual. If this person can afford the everyday necessities and many of the luxuries of our society, then it is reasonable to assume that he can afford to pay a reasonable fee. If this person is an indigent, he obviously needs financial aid in order to have the services performed. If private, local, and State agencies have all refused to act for this individual, then the Federal Government should consider the problem.

We submit that S. 917 should be confined to answering the above-mentioned needs.

(1) Preventive dentistry through:

(a) Patient education concerning dental care;

(b) Fluoridation and similar projects which materially aid the patients' dental health.

(2) Patient education to seek regular and routine dental care and not rely on pain as a cue card to call the dentist.

(3) Assisting State and local welfare agencies presently existing and those to be established in order to provide ear-marked funds for needy individuals who desire dental services.

The Alabama Dental Association, at its 93d annual session, voted unanimously to adopt the following resolution concerning S. 917, and feels that the adoption of this resolution, to serve as an amendment to S. 917 or to be placed in the instructions for administering S. 917, will serve to see that the above-mentioned needs are satisfied. It is our keen desire that the basic points, as set out in this resolution, will be incorporated into this piece of legislation so as to limit the scope of the bill and rule out the possibility that the funds for this bill will not be spent for uses other than are truly thought of as bona fide public health service activities.

The resolution reads as follows:

Whereas the Alabama Dental Association endorses the philosophy which led to the writing of S. 917; and

Whereas the Alabama Dental Association fully intends to support legislation which will lead to better dental health for all the people and will aid in implementation of such legislation and will cooperate as private practitioners of dentistry in areas in which our cooperation is desired; and

Whereas the Alabama Dental Association feels that S. 917 is a definite step forward in providing dental care and education in those areas in which there is great need, however, the Alabama Dental Association solemnly holds that the incorporation of the principles of dental services and education of peoples as outlined in the following paragraph would serve to strengthen S. 917 by clarifying the full intent of the measure to all concerned in its administration and would further ensure that the bulk of the funds appropriated would be spent in those areas in which the need is most acute, that is, dental services and treatment for the institutionalized, the homebound elderly, inhabitants of nursing homes, indigent children, and other classifications as set forth in the following paragraphs: Therefore, be it

Resolved, That the Executive Council and the Alabama Dental Association, at its 93d annual meeting, approve S. 917 with the following provisions:

(1) The kinds of dental public health services which should be covered are such recognized activities as dental health education, fluoridation of community water supplies, and demonstrations of topical fluoride application. It would seem that the public-at-large would be the beneficiaries of these kinds of activities.

(2) The persons for whom the treatment should be extended are those in especially difficult circumstances such as the physically handicapped, institutionalized patients and the homebound elderly. The public health dentist and his staff would be interested mainly in the planning of programs for bringing care to institutionalized patients for example, or the elderly homebound. If

should be expected that the treatment and care would be provided by private practitioners, so far as possible.

(3) The training courses for dentists would be designed mainly to train privately practicing dentists in methods best adapted to care for the chronically ill, handicapped children or the homebound elderly.

(4) S. 917 should not compel any State dental association to follow a specific pattern in developing its dental public health program. If the State of Alabama, for example, wishes to expand its program for providing dental care to indigent persons, support from S. 917 should be available for that kind of program.

The membership of the Alabama Dental Association fully recognizes the need for legislation such as S. 917, but it is felt that unless certain safeguards, such as are outlined in the above resolution, are in some manner affixed to the bill, that the administration of the bill could possibly get out of hand and thereby put the Federal Government in the field of socialized dentistry which would, of course, be a tragedy as far as the dental health of the citizens of the United States are concerned.

There is also the possibility that if the Administrator did get out of bounds, many of the States, which are just beginning to move into the field of public health dentistry, will drop such programs entirely and thereby cause S. 917 to work to the disadvantage of those individuals it is designed to aid.

The members of our association strongly feel that if a valuable service can be obtained free of charge, it will soon become valueless and will not be sought after at all. This very definitely applies to dental services and if this situation developed, the dental health of the community would suffer irreparable damage.

I want to point out that the reason this was brought out in this manner is the explanation of Senate bill 917 which I received from your office, Senator. It was prepared by the Joint Committee on Dental Grants-in-Aid, the American Association of Public Health Dentists, and the Dental Section of the American Public Health Association.

There were certain statements in here which we felt needed clarification and we felt needed to be spelled out in black and white in the bill. Just as an example, it points out that—

this complement of personnel limited to basic staff in small States and more elaborate staff in the larger States would provide the framework with which to plan and care for an effective State dental program designed to bring specific dental public health service to people in communities.

It does not say what people would receive these services. I think it should.

It also says:

For example, for assistance of local health department personnel in conducting factual surveys to determine the extent of community dental disease problems and the local resources for meeting the needs, assistance in planning effective programs which would use both State and local resources for prevention and treatment of dental diseases.

It does not say who will receive those treatments.

That boils down our basic presentation.

THE CHAIRMAN. We want to thank you, Doctor.

Mr. Russell, is there anything you would like to add?

MR. RUSSELL. Nothing, sir, except to say that it is a real pleasure to be here. This is the first time I have had an opportunity to appear before the subcommittee.

The CHAIRMAN. We are glad to have you.

Senator YARBOROUGH?

Senator YARBOROUGH. Before I am forced to leave I would like to ask one other thing of Dr. Hillenbrand.

Dr. HILLENBRAND, on your statement you mentioned the per capita basis for the States, what they were doing in this public health program, that the average yearly expenditure was less than 2½ cents in 1958, and in eight States was less than a penny per person. Do you have a table showing those statistics by States?

Dr. HILLENBRAND. We can get it to you, yes.

Senator YARBOROUGH. I would like for that to be added to the record.

Senator HILL. If you can supply that table we will put it in the record at this point.

Dr. HILLENBRAND. I will be glad to.

(The table referred to follows:)

TABLE 2.—*Per capita expenditures for dental public health and all public health (1958-59)*

States	Per capita expenditures		Percent of all health expenditures devoted to dental health
	Dental public health programs	All public health programs	
United States.....	\$0.024	\$2.54	0.9
Alabama.....	.017	2.00	.8
Arkansas.....	.009	1.82	.5
California.....	.005	3.05	.2
Colorado.....	.028	2.37	1.2
Connecticut.....	.024	2.35	1.0
Delaware.....	.046	2.52	1.8
Georgia.....	.100	3.22	3.1
Hawaii.....	.031	7.75	.4
Idaho.....	.047	2.17	2.2
Illinois.....	.020	1.62	1.2
Indiana.....	.016	1.29	1.2
Iowa.....	.008	1.12	.7
Kansas.....	.012	1.71	.7
Kentucky.....	.064	2.17	2.9
Louisiana.....	.012	2.64	.5
Maryland.....	.076	3.89	2.0
Massachusetts.....	.011	2.79	.4
Michigan.....	.013	2.44	.5
Minnesota.....	.015	1.69	.9
Mississippi.....	.011	2.18	.5
Missouri.....	.003	2.05	.1
Montana.....	.102	1.83	5.6
Nebraska.....	.010	1.27	.8
Nevada.....	.255	3.02	8.4
New Hampshire.....	.044	1.92	2.3
New Jersey.....	.015	2.17	.7
New Mexico.....	.050	2.55	2.0
New York.....	.007	4.69	.1
North Carolina.....	.055	2.44	2.3
North Dakota.....	.031	2.21	1.4
Ohio.....	.004	1.99	.2
Oklahoma.....	.031	2.07	1.5
Oregon.....	.018	2.54	.7
Pennsylvania.....	.061	2.45	2.5
South Carolina.....	.045	2.20	2.0
Tennessee.....	.069	2.39	2.9
Texas.....	.006	1.87	.3
Utah.....	.038	2.29	1.7
Virginia.....	.043	3.06	1.4
Washington.....	.012	2.71	.4
West Virginia.....	.011	1.73	.6
Wisconsin.....	.008	1.97	.4

Source: American Dental Association.

The **CHAIRMAN**. The next witness is Dr. Wesley Young, vice president of the American Society of Dentistry for Children.

Dr. Young, you may proceed in your own way.

**STATEMENT OF WESLEY O. YOUNG, D.M.D., M.P.H., VICE PRESIDENT,
AMERICAN SOCIETY OF DENTISTRY FOR CHILDREN**

Dr. YOUNG. Mr. Chairman and members of the committee, I am Dr. Wesley O. Young, of Boise, Idaho, chief of the Child Health Division of the Idaho Department of Health. I am vice president of the American Society of Dentistry for Children, a member of the Association of State and Territorial Dental Directors and for a number of years have been chairman of the Committee on Grants-in-Aid of the American Association of Public Health Dentists.

I am appearing today as a State dental director, as a representative of the dentists who have specialized in public health and, in particular, of those specialists in dental public health who work in official health agencies. In my capacity as an officer of the American Society of Dentistry for Children I am expressing the conviction of this organization that strengthening State dental divisions is of vital importance in improving the dental health of children.

Previous testimony has outlined the extent of the dental health problem in this country. Dental diseases, as other speakers have pointed out, affect almost everyone. About 15 percent of the personal expenditures for health services go for the treatment of dental diseases. Despite this expenditure only a small proportion of the population actually receives adequate dental care. Rather than repeat or re-emphasize the statistics which prove the seriousness of dental diseases as a public health problem, I will discuss briefly some of the ways in which the dental divisions of State health departments attempt to prevent and control dental diseases, the current status of their programs, and the need for additional financial support.

Dental public health programs have as their objective the establishment and maintenance of high standards of oral health. In attempting to discharge this great responsibility, the public health dentist is concerned with all aspects of dentistry. He must plan programs which will serve, on the one hand, as a bridge between the public and the dental profession, assuring that adequate dental care is available for all—and on the other hand, as a bridge between the research center and the practitioner, assuring that the findings of research will be applied as rapidly as possible.

A dental division cannot, any more than a State health department, do all things for all people. Nor should it. Instead, it concentrates upon providing those services and those programs which cannot be provided as well by other agencies.

In dental health, this means not only programs of health education to combat indifference to the need for dental care but also the promotion of an adequate supply of manpower. It means not only studies of the extent of dental diseases among the population but also the effective application of preventive measures. It means not only the traditional programs of treatment for the indigent but also care programs for other groups—the handicapped, the homebound—whose needs cannot yet be met by the majority of practicing dentists. These measures, and others, are necessary to the ultimate goal of dental pub-

lic health programs—the control of all dental diseases in all our people.

The dental divisions of few State health departments now offer, or can envision offering, comprehensive programs in all these areas—essential as they are. And though the efforts of another agency may occasionally fill to a degree the gaps in dental programs—welfare agencies, for example, sometimes provide dental care for indigent children—the absence of an effective dental program usually means that the need is not being met.

I can best describe the current status of dental health programs and their need for expansion with examples from my own State. The dental program of the Idaho Department of Health is 11 years old. I have served as its director since its organization in 1951. The present staff consists of two public health dentists, a dental hygienist, an administrative assistant, and two secretaries. In 1961, the total annual budget was slightly more, \$105,000, representing an expenditure of almost 16 cents per person. In relation to the size of its population, Idaho has one of the largest dental programs in the United States. In 1961, only the District of Columbia, Hawaii, and Nevada spent more per capita for State dental activities.

The relatively large dental health budget in my State is not cited in any sense of boasting. Though our financial effort is greater than that of most States, I am acutely aware of the inadequacies of our present dental program. In almost every area, our efforts represent no more than a beginning. And the pattern in Idaho is typical of that in other States.

The application of preventive measures against diseases is a basic function of a health department. In dental health, we have two highly effective methods of preventing dental decay, the chief cause of tooth loss in children and young adults. One of these, fluoridation of community water supplies, is an ideal public health measure; it is inexpensive; its benefits accrue to everyone in the community. The promotion of water fluoridation started early in Idaho, soon after the city of Lewiston adopted the measure in 1947. Between 1952 and 1955, 17 additional Idaho communities instituted controlled fluoridation. Unfortunately, the initial enthusiasm did not last. Since 1955 only three additional communities have adopted the measure.

And because our dental staff is not large enough to promote fluoridation throughout the State and provide consultative services to its many small communities, our attempts to win acceptance for the measure have been ineffective.

A second preventive measure, topical application of a fluoride solution to the teeth of children, similarly is neglected. This procedure is an important part of dental practice, yet only a small proportion of children now receive the protection against dental decay which it offers.

Nationally, only 20 percent of dentists in private practice apply topical fluorides routinely. In Idaho, we estimate that an even smaller proportion makes this service available to their patients. We have attempted to provide topical applications through community programs in rural areas, but because of shortages of funds and personnel, only about 1,200 children—less than 0.4 percent of the children in the State—receive topical fluoride applications through community programs each year.

Programs in other States are equally limited. Of the 46 State dental programs studied in 1959 by the American Dental Association, 21 reported no activity to promote community topical fluoride programs. Only two States claimed to have adequate programs. As for direct provision of topical fluoride application, 20 of the 46 States reported no activity, and not one considered its program adequate.

A comprehensive State dental health program would encourage maximum utilization of topical fluoride applications in all areas where community water supplies are not fluoridated. This would be done by encouraging dentists to provide the applications routinely in their private practice, by stimulating parents to request the service from their dentist, and by providing applications directly through community public health programs.

Efforts to attain maximum utilization of preventive measures should be closely allied to dental health education programs. Public acceptance of water fluoridation and topical fluoride applications is dependent upon understanding the value of these measures. So is the use of other methods for the prevention and control of dental diseases.

Dental health education has always been a major component of dental health programs. Nevertheless, current activities can be characterized only as grossly inadequate. In Idaho we spend less than \$15,000 a year on dental health education programs. All of the State health departments throughout the United States spend only about \$400,000 annually for dental health education. Dentifrice manufacturers, in contrast, spend \$36 million annually on advertising—advertising which is often misleading and sometimes detrimental to the improvement of dental health.

In my State we have felt that the limited resources available for health education could be utilized best by emphasizing the development of local dental health education programs. Under our plan, at least one dental hygienist would be employed full time in each major community, to provide consultation to teachers to improve the quality of dental health instruction in the schools, and to conduct referral activities designed to motivate parents to seek regular dental care for their children. After 9 years of effort, only two local programs are in operation and these are not yet staffed with full-time dental hygienists—because the salaries that we can offer are too low to attract qualified hygienists. The dental health education activities for the entire State currently are conducted by one hygienist who works full time and by another who works 2 days a week. Since consultation to teachers is an important part of a health education program, the contrast between the need and the available resources is probably best illustrated by the fact that there are more than 7,000 teachers in Idaho.

Other State health departments are in a similar position. The 1959 survey of State dental programs listed 12 commonly used methods of health education. Only one State indicated that its use of as many as five of these methods was adequate. Thirty-nine of the forty-six States reported that their use of all the 12 methods was inadequate.

Because financial resources are limited and staffs are small, dental divisions are forced to assign priority to certain activities. The prevention of diseases, particularly through the use of measures which

will benefit entire communities, is one activity which is emphasized. Another is the improvement of the oral health of children.

With adequate dental care, today's children can escape many of the serious problems adults now endure. Dental care in childhood, combined with instruction in oral hygiene, is the cheapest and best insurance we can buy to ward off another generation of dental cripples.

Unfortunately, relatively few children are receiving this insurance now. By the time the average child reaches his 15th birthday, dental decay has damaged or destroyed 11 of his permanent teeth. Nearly one-third of all children between the ages of 5 and 15 never visit a dentist.

Many families do not have the resources to obtain care for their children. Society traditionally meets its responsibility to children from these families through public agencies, yet public programs providing dental care for indigent children are pitifully inadequate.

Other families cannot obtain proper care for their children because of special circumstances. The dental health of countless handicapped children such as the victims of cerebral palsy and other neurologic disorders, the mentally retarded, and the emotionally disturbed children who often require special handling in the dental chair—is neglected. The private dentist is seldom prepared to treat these children and public programs for them are almost nonexistent. Many children in isolated rural areas do not receive treatment because they live too far from the dentist and there are no community programs to bring dental care to their area.

The national picture is reflected by the situation in Idaho. None of the 44 counties in the State has a regular program to provide dental care for indigent children. Less than 500 children a year receive complete dental care through organized public programs. In general, children from indigent families receive only emergency care, when the family or another interested party imposes on the generosity of a practicing dentist.

Handicapped children are even less likely to receive the dental treatment they need in most areas of the country. In Idaho, there is a care program for handicapped children. This program, offering dental care to about 300 cerebral palsied, mentally retarded, and physically handicapped children was made possible only by a contract with the Division of Dental Public Health and Resources of the Public Health Service.

No other State has a comprehensive program to offer complete care to all children suffering from these handicaps. And those facilities which are available for handicapped children are frequently located in large urban centers.

The activities I have mentioned are but a few of those a comprehensive dental health program should encompass. Though commendable beginnings have been made in some areas, much more remains to be done. The need for the expansion of existing activities and for the initiation of others is urgent. The passage of S. 917 would be a major step toward meeting this need. Earmarking Federal grants for dental public health programs would, I am convinced, stimulate State support—support which in most States has never been sufficient to permit even the building of basic staffs and programs.

All State health programs are the victims of low budgets. Because State appropriations are rarely large enough to meet the need for services, many programs are in chronic financial difficulty.

Adequate financial support is probably most common for those disease control programs which have received earmarked categorical Federal support—such as venereal diseases, heart, mental health. State appropriations for these programs rose dramatically after categorical grants became available. Those programs which must be supported by general health grants and State appropriations are not so fortunate. And this is particularly true in dental health.

Of every \$100 allocated by the States for State health departments, dental programs receive 70 cents. Our share of the general health grants administered by the Public Health Service is equally low. Of the \$17 million in general health grants made available to State health departments in 1961, only \$125,000—less than 1 percent of the total—was allocated to dental programs.

Medical programs are naturally the first concern of the physicians who direct State health departments. As a result, many are reluctant to allocate more than token budgets for dental programs. Those who would provide greater support, like the health officers under whom I have served in Idaho, are deterred by budgets which cannot be spread to cover every service fully.

The passage of S. 917 would in large measure eliminate these barriers to the adequate financing of dental public health programs. By requiring matching funds from the States, it would stimulate the use of State and local funds for this purpose. By earmarking grants for dental programs, it would assure those programs an equitable share of the public health dollar. Dental divisions could then begin to build the programs and staffs essential to an effective attack upon the dental health problem. I respectfully urge your support of this important legislation.

The CHAIRMAN. Any questions, gentlemen?

Senator JAVITS. I just wanted to ask this witness one question about the fluoridation of water, which is apparently a very controversial subject. Many groups have agitated against it on the ground that it injects an alien element into the water supply. Now, for the understanding of the layman, can you tell us the difference, if any, between fluoridating the water and chlorinating the water, and whether or not it is the general practice in all municipal water supplies to chlorinate water to a greater or less extent, as the case may be?

Dr. YOUNG. I will answer your second question first, Senator Javits. Any public water supply that is not adequately protected from contamination is routinely chlorinated. In a case where you had a deep well supply with no chance of outside contamination, chlorination would not be necessary.

Your first question I might turn around. I do not profess to be a chemist, but chlorine and fluorine act quite differently in water. Chlorine is added to the water to remove contamination, and in the process it disappears from the water after a period of time.

Fluorine, once in the water, remains there constantly and consistently.

I might add that in Idaho and a number of Western States we have lived with fluorine for many years, and it is difficult for us to understand the attitude of some of the opponents. Almost a third of our water supply has fluorides in about the right amount naturally. This is added by the Almighty when this water passes over underground

rocks that contain fluorides, and then it is pumped to the surface. And it is difficult for us to see the difference between mining the rock and adding the fluoride after the water comes to the surface.

Senator JAVITS. Very good. As a leader in the field you would certainly strongly advocate fluoridation of water supplies generally?

Dr. YOUNG. Very, very strongly.

Senator JAVITS. Now, is there any question whatever about the scientific justification for fluoridation as representing a real deterrent to tooth decay?

Dr. YOUNG. I do not believe that any public health measure, any preventive measure ever had the extensive study that fluoridation had before it was recommended, and the evidence is just overwhelming, there was study after study repeating the same thing. And there is certainly no question of its safety and its effectiveness. I happen to have been raised in a community that has 1.5 parts per million in the water supply, and I can even testify from personal experience; I have had about three cavities, which is way below the national average, and all of my neighbors have had the same experience. So either as a person or as a scientist I endorse it.

Senator JAVITS. I certainly thank you. I think it is most important that this be made known. I think the type of people that sends us mail wanting the United States to withdraw from the United Nations, wanting to impeach Earl Warren, and to indict Eisenhower as a tool of the Communist conspiracy, is also against fluoridation as poisoning the resources of nature. And you are lucky to have it as a part of the resources of nature.

Thank you very much for your testimony.

The CHAIRMAN. Senator Pell?

Senator PELL. I think you mentioned an alternative to fluoridation, or the topical application of it. What is that?

Dr. YOUNG. This requires a dentist or a dental hygienist to do a cleaning of the teeth, and then they are dried, isolated just as soon as they can be dried just like when you are having a tooth filled, and then a solution of fluoride, a relatively strong solution, is applied and allowed to dry on the teeth. And in a large population of children this will reduce new tooth decay by about 40 percent. It is an effective measure, but it is far less effective than water fluoridation. We have considerable doubt about its lifelong effectiveness, even though it does protect them during this very important period of childhood. It is quite expensive, and so far it has not reached any large segment of the population.

Senator PELL. What is your opinion of the two dentifrices which have fluorides in them?

Dr. YOUNG. I can only give you my personal view. One of the dentifrices has been recognized by the American Dental Association's Council on Dental Therapeutics. After carefully weighing the evidence, the council found reason to believe, it is effective. But I believe it will take time and an additional study to know just what impact this will have nationally.

Senator PELL. In your view could that be substituted for the fluoridation of water?

Dr. YOUNG. In my judgment the reductions from the use of the fluoride dentifrice are so much smaller—they are a much more limited kind of reduction. I believe they might be a valuable addition to water

fluoridation, but I don't think they are going to make any dramatic difference in the overall problem.

Senator PELL. Thank you.

The CHAIRMAN. I have a list compiled by the American Dental Association of national organizations that have adopted policies favorable to fluoridation. I think it might be well to put the list in the record at this point.

(The list referred to follows:)

NATIONAL ORGANIZATIONS WHICH HAVE ADOPTED POLICIES FAVORABLE TO
FLUORIDATION

American Cancer Society.
 American Nurses Association.
 American Hospital Association.
 Federal Civil Defense Administration.
 U.S. Department of Defense:
 U.S. Army.
 U.S. Navy.
 U.S. Air Force.
 American College of Dentists.
 Conference of State Sanitary Engineers.
 American Pharmaceutical Association.
 American Association for the Advancement of Science.
 National Institute of Municipal Law Officers.
 American Society of Dentistry for Children.
 American Dental Association.
 American Medical Association.
 American Academy of Pediatrics.
 American Public Health Association.
 American Public Welfare Association.
 American Water Works Association.
 American Institute of Baking.
 American Institute of Canning.
 American Society of Brewing Chemists.
 American Association of Public Health Dentists.
 State and Territorial Dental Health Directors.
 State and Territorial Health Officers Association.
 U.S. Department of Health, Education, and Welfare:
 Food and Drug Administration.
 Public Health Service.
 National Institutes of Health.
 National Research Council.
 The Johns Hopkins University School of Hygiene and Public Health.
 University of Pittsburgh School of Public Health.
 Association of Casualty & Surety Companies.
 The Travelers Insurance Co.
 Inter-Association Committee on Health:
 American Dental Association.
 American Hospital Association.
 American Medical Association.
 American Nurses Association.
 American Public Health Association.
 American Public Welfare Association.
 Commission on Chronic Illness.
 National Congress of Parents & Teachers.
 American Legion.
 U.S. Junior Chamber of Commerce.
 American Federation of Labor & Congress of Industrial Organizations.
 American Society of Clinical Pathologists.
 Child Study Association of America.
 College of American Pathologists.
 Industrial Medicine Association.
 American Dental Hygienists Association.
 American School Health Association.
 Joint Committee on Health Problems of the American Medical Association and
 the National Education Association.

The CHAIRMAN. We want to thank you for a very fine statement, Dr. Young.

The next witness is Dr. Polly Ayers, director, Bureau of Dental Health, Jefferson County, Birmingham, Ala.

Doctor, we are glad to have you here with us. And you may proceed now in your own way.

STATEMENT OF POLLY AYERS, D.D.S., DIRECTOR, BUREAU OF DENTAL HEALTH, JEFFERSON COUNTY, BIRMINGHAM, ALA., REPRESENTING AMERICAN ASSOCIATION OF PUBLIC DENTISTS

Dr. AYERS. Mr. Chairman and members of the subcommittee, I am Polly Ayers, a public health dentist from Birmingham, Ala., and a member of the Committee on Legislation of the American Association of Public Health Dentists. I am here primarily to point out to you how much help the passage of Senate bill 917 could be to citizens who live in areas served by local public health dental programs such as the one which I have directed in Jefferson County, Ala., for the past 15 years. My interest, however, in this bill goes far beyond the boundaries of one county in Alabama. I know that citizens throughout our entire State would benefit if this legislation is enacted. I know this because since 1959 I have served as chairman of the Committee on Dental Health of the Alabama Dental Association, an association which has long been seriously concerned with finding ways to improve the dental health of the people of our State. In fact, the dentists of Alabama were among the first in the country to urge enactment of legislation authorizing Federal earmarked funds for dental public health programs.

Our dentists have been particularly concerned about finding ways to provide dental services for the poor people of Alabama and especially for the children of poor people. They are also concerned about the dental needs of the homebound, the elderly, and the handicapped. I am submitting with my statement three resolutions concerning Senate bill 917 which have been endorsed by the General Assembly of the Alabama Dental Association. I believe they will indicate to the members of the committee how seriously and how thoroughly our members have weighed the benefits to be derived from the proposed legislation which you are considering today.

I have also been president of the American Association of Public Health Dentists, an organization composed of dentists from across the Nation who are engaged in all types of public health activities. Some are employed in State dental programs, some are employed by counties or municipalities, some serve institutionalized people and some are members of the facilities of schools of public health. For a number of years this association has had an active committee on Federal grants-in-aid. I can assure you that interest in Senate bill 917 is very high among members of the American Association of Public Health Dentists.

I know we need Federal funds earmarked for dental public health throughout the United States. I know our needs for such funds are great throughout my own State of Alabama, but most of all I know firsthand that we need this type of financial assistance in Jefferson County, Ala.

The Jefferson County Department of Health with headquarters in Birmingham is considered by many public health experts to be one of the better local health departments in the United States. Nationally, we have been recognized for our efforts in the fields of housing, premise sanitation, air sampling, home accident prevention, milk control, venereal disease control, services for the chronically ill and aged, and even our dental program has come in for its share of accolades. Much of the credit for the success we have had is due to our long-time brilliant and visionary health officer, Doctor George A. Denison, who has constantly found ways to keep our programs up to date in spite of the fact that he has had to wage a continuous fight for local, State, and Federal funds to finance our operations. In fact, it was not until last year that we could state for the first time that every governing body in our county had made at least a token appropriation to our health department. About 80 percent of our health department budget is derived from local sources. These local contributions do not begin to take care of the health needs of our people. We must turn to State and Federal sources for additional funds. As a matter of fact, our dental budget allows us to spend less than 6 cents per person per year on programs designed to improve the dental health of Jefferson County citizens.

I have said that nationally our health department ranks high among the local health department programs, and I have indicated that our health officer has been responsible for much of our success. Credit is also due to our many dedicated employees who seem to enjoy ignoring time clocks and coffee breaks in order to shoulder new burdens which offer a chance to explore new ways of improving the health of our people.

Even though from afar our program appears to be an especially fine one, those of us who are closer to the scene know that there is much room for improvement. We also have a strong feeling that money could solve most of our problems.

This is certainly true in our dental program. We should be reaching many more people through our dental health educational program. We should be spending much more time in working toward fluoridation of all of our public water supplies. There are many poor people in our county who are receiving no dental treatment services. We should be developing programs to help them. We provided topical fluoride treatments for only 1,800 school children last year. There are over 200,000 children in Jefferson County under 15 years of age. Many more than a paltry 1,800 of these should have been reached through our program. We are providing dental services for a small group of ambulatory chronically ill and aged people who are in great financial need. We have had no services available in our country for nonambulatory people in homes or institutions. Our health department needs to supplement the services offered by our dental school for handicapped individuals, for instance, the epileptics, the cerebral palsied, the mentally retarded, and those with cleft palates.

We are not able to expand our dental program as we know we should because we do not have enough people on our staff to assume responsibility for these added tasks. For 10 years we have had only six full-time people on our dental bureau staff. This number includes

our secretary. I am the only full-time dentist and the only one with formal training in public health. We have one dental health educator who must serve also as a clinical dental hygienist and as a dental assistant. Two hygienists and an assistant complete the picture.

We are supposed to improve the health of 650,000 people. This, of course, is an impossibility. We must, therefore, constantly direct our energies toward small portions of this population where we see the greatest need or where we can bring about the greatest improvements in dental health. We must do this because we do not have the funds to employ a staff of the size and caliber we need to develop the kind of public health dental program we know we should have in Jefferson County. Our lot could be greatly improved if we could obtain Federal matching funds.

There are many communities all over the United States with no dental program whatsoever. As best I have been able to ascertain, there are only 94 local dental health programs in the entire country which are directed by full-time dentists. These 94 programs are in 28 of our 50 States. There are, therefore, 22 States without a single local dental public health program directed by a full-time dentist.

To point out this shortage in another way, there are 213 urbanized areas in the United States, that is, areas which have at least one city with a population of 50,000 people surrounded by a closely settled area. Of these 213 urbanized areas, there are still 120 which do not have dental programs directed by full-time dentists. These are communities which could be stimulated to develop dental programs if S. 917 becomes law. This in itself should be justification enough for making Federal earmarked dental funds available because three-fourths of the people in the United States live in these 213 urbanized areas.

A modern dental public health program should embrace four major categories of activities: dental treatment programs, activities directed toward the prevention of dental diseases, dental health education, and dental public health research. I should like now to point out to you what we are presently doing in each of these areas and then indicate what we could be doing if we had additional funds at our disposal.

DENTAL TREATMENT PROGRAMS

In our county we have dental equipment in four health centers and in two dental trailers. Since 1951 we have had no funds to employ dentists on a routine basis at any of our health centers. As you well know, Children's Bureau funds can be used to employ either medical or dental clinicians. The amount which the Jefferson County Department of Health has received each year since 1951 has been used to pay physicians fees only. It has not been considered adequate to finance also any fees for dentists.

Our dental trailers were purchased with local money raised each year when our best high school football squads compete in our children's dental clinic championship football games. From this same source we receive an appropriation large enough to employ supervising dental clinicians four mornings each week during the school year. These dentists supervise the work of three dental students who are assigned each week to participate in our dental trailer

program which serves rural elementary schools. This is the only dental treatment service which has been rendered directly by our health department since 1951. We do well if we complete the dental needs of five poor children in any given week.

We also employ a dentist to examine and refer poor, older patients who attend a chronic disease clinic held once each week. Limited dental services from these patients are purchased by the health department from the University of Alabama School of Dentistry.

Last year about 250 chronically ill adults and about 200 children were the beneficiaries of dental treatment services provided through our health department. Currently we do not have the staff or the equipment to do more than this and yet the expected population explosion will add 52 more teeth for some dentist to worry about every time another baby is born. Some of those teeth are bound to become the responsibility of public health dentists throughout the country.

It is obvious that we are not meeting the dental needs of poor school-children. We have nothing to offer needy teenagers. If one is a poor adult, he must also have a chronic disease before he can have any hope of obtaining any dental services. We are providing no dental treatment for people who are handicapped or homebound or for non-ambulatory people who reside in nursing homes. If this bill is passed we would immediately take steps to update our four health center dental clinics and to staff on a full-time basis both the health center clinics and the two dental trailers.

PREVENTIVE DENTISTRY

Public health dentists are far more interested in the prevention of dental diseases than they are in providing dental services for already crippled mouths. They know that the most logical, efficient, and economical approach to our Nation's mammoth and increasing dental problem is to utilize all sound ways to reduce the size of the problem by preventing dental diseases wherever possible.

The fluorides, applied to the teeth or furnished in drinking water, have proved to be highly effective in preventing dental decay. For this reason, we devote as much time as funds and available staff will allow to providing fluoride treatments for children. The problem is that we cannot begin to reach all of the youngsters whose teeth should be protected from decay by our dental staff.

I have one clinical dental hygienist who provides stannous fluoride treatments for children and oral prophylaxes for prenatal patients one day per week in each of our health center dental clinics. Additionally, from time to time, she uses portable equipment set up in classrooms. Our other hygienist is needed as a dental assistant during the mornings when dental students work with us. This reduces the amount of time available for her to provide fluoride treatments. Our dental health educator serves in three capacities: as an educator, as a clinical dental hygienist, and as an expert dental assistant. Only a very small portion of her time can be devoted to providing fluoride treatments. In addition, the dental students assigned to the trailer program spend one morning each week learning the topical fluoride technique and a few children benefit from this training session.

We therefore have only one person, a dental hygienist, devoting full-time to preventive dental techniques. The other staff members do what they can in this field, but their time is limited. The dental students are just learning the technique, hence, their contribution to our topical fluoride program is helpful but does not reach many youngsters.

If Senate bill 917 is passed, we could do much to improve the dental health of Jefferson County citizens by employing more dental hygienists and by employing dental assistants in sufficient numbers so that our hygienists would be relieved of assistants' duties. They could, then, be used to perform full time the functions for which they have been especially trained.

DENTAL HEALTH EDUCATION

Our dental health educator is bogged down at least half time with clinical activities. In the time she has had available for dental health educational activities she has developed excellent dental teaching aids which are used in our schools, she has made many classroom talks, she has worked with groups of schoolteachers to provide them with dental information and to suggest useful techniques for imparting dental health information to children, she has helped to encourage dental assistants and dental hygienists from private dental offices to take part in continuing education courses which she has either taught or organized, she has been responsible for keeping members of our own staff well informed through in-service training programs and she has served as a source of information on dental subjects for many people who turn to our office for advice.

Our dental health educator has accomplished much, but she and I both know that there is a tremendous need for increasing our activities in this field. It is fairly common knowledge now that there is a direct relationship between how well informed an individual is about dental health and the status of his own dental health. In addition, we know that an educated parent will be more inclined to seek dental care for his child.

Our basic health programs in the United States have already raised dental health standards far above those in the less well developed countries. For instance, in India and in Egypt many people still die each year as the result of dental infections. We do not very often hear of a death from dental infection in this country. We live in a country where our standard of living demands better dental health than that. We are concerned with such things as optimum health, appearance, the financial burden of absenteeism due to preventable dental ailments, the lamentable fact that so many military inductees require extensive treatment for dental conditions which could have been prevented or controlled, and the fact that 10 percent of all cancers occur in the mouth.

Even though many of us in this country think in terms of the contribution optimum dental health can make to an individual's feeling of well being, his economic security and his social success, there are still many among us who need to be taught how optimum dental health can be accomplished. This is one good reason why we need dental health educators.

We also are sorely in need of dental health educators to teach those who do not yet know how much could be accomplished for communities through the fluoridation of fluoride-deficient water supplies. This one procedure, fluoridation, could do more to reduce our Nation's dental problem than any other method yet developed and competent dental health educators would be very valuable assets to communities if they did nothing else but motivate citizens to obtain fluoridated drinking water for their children.

We also wish that we had time and staff to provide dental health information for future teachers. Teachers are trained at four colleges in our county. We do not have the staff to offer short courses on dental health at any of these schools and yet these are the institutions where many of the public school teachers in our county receive their education. If they were better informed about dental health, they would eventually be in a position to impart this information to their students.

DENTAL PUBLIC HEALTH RESEARCH

There are certain types of information which can best be obtained by exploring health problems at the community level. A public health dentist could make real contributions to the improvement of dental health by studying the people who live in the area he serves. This is the way beneficial effects of the fluorides came to light.

Our efforts in the field of dental public health research have been minimal in Jefferson County, not because there is nothing to study, but mainly because we have such a small staff and so little time to devote to any activities other than those related to dental services or dental health education. If we had the additional funds which Senate bill 917 could make available through its special project grants we would be interested in investigating such areas as: the most appropriate ways of providing dental health information for school children; the special techniques needed to provide dental services for people who are physically or mentally unable to receive care in the usual dental office setting; and, we would investigate the usefulness of the smear technique for identifying oral cancer in large population groups.

I have pointed out that we in Jefferson County have had difficulty in securing sufficient funds to operate the type of dental program the people in our county need. On many occasions I have attempted without success to obtain local, State, or Federal funds to improve our program. On at least nine occasions I have prepared written requests for specific projects which would have made it possible for us to render new, or more, or better services. I have asked for funds to train our dental clinicians in the use of preventive orthodontic techniques. I have asked for funds to employ dental hygienists, dental assistants, dentists, and for an administrative assistant. I have asked for funds to update the dental equipment in our health centers. None of these requests have been approved. Usually the funds desired were allocated to some nondental project. I believe this would not have been the case if funds specifically earmarked for dental public health had

been available. For the above reasons based on the experiences of many years I urge enactment of Senate bill 917.

The CHAIRMAN. Doctor, I happen to know of my own personal knowledge that you have long been one of the strongest advocates and supporters of this legislation in the whole United States. And we certainly want to thank you for your presence here this morning and your statement. We appreciate it very much. Thank you, Doctor.

Do you want to put the texts of the resolutions in the record?

Dr. AYERS. The three resolutions. One is the same resolution presented by Dr. Lamar, and there are two additional ones.

The CHAIRMAN. Do you want to have all those in the record?

Dr. AYERS. All three of them.

The CHAIRMAN. They will appear at the conclusion of your remarks. (The resolutions referred to follow:)

RESOLUTION, ENDORSED DECEMBER 11, 1960, BY THE EXECUTIVE COUNCIL OF THE ALABAMA DENTAL ASSOCIATION AND ENDORSED APRIL 1961 BY THE GENERAL ASSEMBLY OF THE ALABAMA DENTAL ASSOCIATION

Whereas to date insufficient funds have been available through the State Legislature of Alabama to conduct adequate dental public health programs in Alabama; and

Whereas members of the committee on legislation of the Alabama Dental Association for the past several years have been striving to obtain either State and/or Federal funds for the operation of dental public health programs in Alabama; and

Whereas members of the committee on dental health of the Alabama Dental Association have recommended that efforts be continued to secure the legislation necessary to allow the U.S. Public Health Service to provide funds to the States specifically earmarked for dental public health activities; and

Whereas Senator Lister Hill, at the urging of the officers of the American Dental Association has now introduced before the Congress of the U.S. Senate bill 3780 for the specific purpose of enabling the Surgeon General of the United States to assist States, counties, health districts, and other political subdivisions through grants, in establishing and maintaining adequate measures for the prevention and control of dental diseases, including grants for demonstrations and the training of personnel; and

Whereas an all-out effort will be made in 1961 by the American Dental Association to secure passage of Senate bill 3780: Now, therefore, be it

Resolved, That the members of the executive council of the Alabama Dental Association give their wholehearted approval of the efforts being made by committees of the Alabama Dental Association and by the American Dental Association to secure appropriations at both Federal and State level earmarked for conducting adequate dental public health programs.

RESOLUTION, ENDORSED DECEMBER 11, 1960, BY THE EXECUTIVE COUNCIL OF THE ALABAMA DENTAL ASSOCIATION AND ENDORSED APRIL 1961 BY THE GENERAL ASSEMBLY OF THE ALABAMA DENTAL ASSOCIATION

Whereas the members of the executive council of the Alabama Dental Association recognize the great need which exists to improve the dental health of Alabama citizens; and

Whereas it is hoped that increased earmarked dental health funds will be made available by the State Legislature of Alabama; and

Whereas it is also hoped that the Congress of the United States will approve the inclusion of a dental category in the program for Federal grants-in-aid to States for general health activities: Now, therefore, be it

Resolved, That, when additional funds are made available to the Alabama State Department of Public Health for the expansion of the existing dental pub-

lic health program and for the initiation of new dental health activities, efforts be made to: Secure legislation which will allow payment of more adequate salaries to State dental personnel; increase the size of the State Bureau of Dental Hygiene staff; initiate programs designed to improve the dental health of the chronically ill, the aged, the homebound, the institution bound, and the handicapped; promote the fluoridation of fluoride-deficient water supplies; investigate the extent and nature of dental diseases in Alabama; expand dental health educational activities; provide continuing educational programs for the dentists of Alabama; apply all known measures to control or prevent dental diseases in Alabama; and, protect the public and the dental profession from unnecessary exposure to radiation.

RESOLUTION ENDORSED APRIL 1962 BY THE EXECUTIVE COUNCIL AND SUBSEQUENTLY BY THE GENERAL MEMBERSHIP OF THE ALABAMA DENTAL ASSOCIATION

Whereas the Alabama Dental Association endorses the philosophy which led to the writing of S. 917, and

Whereas the Alabama Dental Association is acutely aware of the needs of such legislation as S. 917, and

Whereas the Alabama Dental Association fully intends to support legislation which will lead to better dental health for all the people and will aid in implementation of such legislation and will cooperate as private practitioners of dentistry in areas in which our cooperation is desired, and

Whereas the Alabama Dental Association feels that S. 917 is a definite step forward in providing dental care and education in those areas in which there is great need, however, the Alabama Dental Association solemnly holds that the incorporation of the principles of dental services and education of peoples as outlined in the following paragraph would serve to strengthen S. 917 by clarifying the full intent of the measure to all concerned in its administration and would further insure that the bulk of the funds appropriated would be spent in those areas in which the need is most acute, that is, dental services and treatment for the institutionalized, the homebound elderly, inhabitants of nursing homes, indigent children, and other classifications as set forth in the following paragraphs: Therefore, be it

Resolved, That the executive council and the Alabama Dental Association, at its 93d annual meeting, approve S. 917 with the following provisions:

(1) The kinds of dental public health services meant are such recognized activities as dental health education, fluoridation of community water supplies and demonstrations of topical fluoride application. It would seem that the public-at-large would be the beneficiaries of these kinds of activities.

(2) The persons for whom the treatment is intended are those in especially difficult circumstances such as the physically handicapped, institutionalized patients and the homebound elderly. The public health dentist and his staff would be interested mainly in the planning of programs for bringing care to institutionalized patients for example, or the elderly homebound. It would be expected that the treatment and care would be provided by practitioners.

(3) The training courses for dentists would be designed mainly to train privately practicing dentists in methods best adapted to care for the chronically ill, handicapped children or the homebound elderly.

(4) It is important to know that S. 917 does not compel any State dental association to follow a specific pattern in developing its dental public health program. If the State of Alabama, for example, wishes to expand its program for providing dental care to indigent persons, some support from S. 917 would be available for that kind of program.

The CHAIRMAN. Dr. Edward Davens, American Public Health Association, and Deputy Commissioner of Public Health, Maryland State Department of Health, Baltimore, Md.

We are glad to have you, Doctor. You may proceed in your own way.

**STATEMENT OF EDWARD DAVENS, M.D., DEPUTY COMMISSIONER
OF PUBLIC HEALTH, MARYLAND STATE DEPARTMENT OF
HEALTH, BALTIMORE, MD., REPRESENTING AMERICAN PUBLIC
HEALTH ASSOCIATION**

Dr. DAVENS. If I may be permitted, I would like to add a footnote to Senator Javits' question of Dr. Young.

One of the greatest blessings in this country is our unlimited, safe and plentiful water supply. Those who have traveled in Europe and Asia and Africa might agree that this might even amount to a fifth freedom. And when you examine the way that this water supply of ours is processed, you are immediately aware that a great number of chemicals have been added in order to do so. In many of the dams small amounts of copper sulfate are added to take care of the excess algae. Chlorine has already been mentioned. This reduces the contamination, and usually one or two parts of that in a million are left in as a residual. Alum is added, that is, aluminium sulfate, to flocculate certain impurities out of the water. Calcium and other salts are almost invariably added in many parts of the country to adjust the acidity of the solution. And I believe there are other chemicals, I am not a sanitary engineer, so I don't know all of them.

But it is absolutely ridiculous to think that adding one part per million is going to contaminate it when the water in Colorado Springs has 10 or 15 parts put in by the Lord. And these irrational groups who worry about this really would do much better if they would direct their efforts to a constructive effort to reduce the pollution of the water supply which occurs from industrial wastes and our overburgeoning population.

Excuse me for that little interlude.

The CHAIRMAN. We are glad to have it, Doctor.

Dr. DAVENS. I am Dr. Edward Davens, of Baltimore, Md., deputy commissioner of public health of the Maryland State Department of Health. Today, I am appearing before you in behalf of the American Public Health Association to request the enactment of S. 917.

The APHA is the professional home of public health workers in all disciplines from private practice, industry, educational institutions, voluntary organizations, and all levels of governmental activity—State, local, and Federal. It has over 13,000 members, with an additional 20,000 members in State and affiliated societies. Our primary interest is in the preservation and promotion of health.

There are many reasons for the initiation and growth of Federal grants-in-aid program. First, and perhaps foremost, is the complexity of society which has come with industrialization and urbanization. With the expansion of the population and the movement into the cities have come many problems of national concern not dreamed of a generation or so ago, and these problems are often most pressing in areas of meager tax resources.

When a Federal aid program is established, it usually is because of the seriousness of the problem and the inability of private organizations and individuals or local authorities to cope with it. This fact is borne out in the history of grants-in-aid in such fields as general health services, and programs for the prevention and control of specific diseases like syphilis and cancer.

The general health grant was started in 1936 as Title VI of the Social Security Act to provide financial assistance and stimulation to the nationwide development and improvement of State and local public health services for the prevention and control of disease, disability, and premature death. Over the years, the basic purpose of the grant has continued to be the strengthening and improvement of a nationwide network of State and local public health organizations and services through which the more specialized disease control programs can operate effectively.

For example, the venereal disease control grant was authorized in 1938, by amendments to the 1918 Chamberlain and Kahn Act. This legislation established the program to control syphilis and gonorrhea in the United States on a permanent, national basis.

The tuberculosis control grant was approved in 1944, to assist States in establishing adequate measures for the prevention, treatment, and control of tuberculosis.

The National Mental Health Act, enacted in 1946, authorized grants to improve community services for the mentally ill and to prevent and curtail their need for hospital care.

The grant for community programs for heart disease control was authorized by the National Heart Act of 1948. This legislation was preceded by several demonstration projects sponsored by the Public Health Service which indicated that programs for the control of heart disease were feasible. The enactment of the National Heart Act provided the needed authority and funds.

Grants for cancer control assist official agencies, professional and voluntary societies and other interested groups in initiating and furthering community programs to reduce morbidity and mortality from cancer.

During the depression years and for the duration of World War II, few hospitals had been constructed in the United States. For this reason, many hospitals had become obsolete and there were shortages in the number of hospital beds and other related health facilities and services. To identify and meet these needs, Congress enacted into law in 1946 the Hospital Survey and Construction Act. This legislation, popularly known as the Hill-Burton Act, is a monumental example of your efforts through the years, Senator Hill, to improve health services and facilities for the American people.

The CHAIRMAN. Thank you, Doctor.

Dr. DAVENS. As a result, the United States undertook, for the first time, an orderly appraisal of its existing hospital and public health center resources.

I might say that in my own State of Maryland the result has been really tremendous.

Federal grants also have provided the initial stimuli and support for State and local water pollution control programs, waste treatment works construction, air pollution control, hospital and medical facilities research and demonstrations, and most recently grants to assist States to increase the availability and improve the quality of community health services, particularly for the chronically ill and aged.

In every one of these programs, without an exception, Federal grants-in-aid has provided the initial impetus for the growth and

progress that followed. By stark contrast, dental health programs have remained at a relatively undeveloped level. So-called treatment programs for children too often are only extraction in clinics, dental health education is pitifully inadequate, and the lack of progress of fluoridation is tragic.

In my own State of Maryland, an unsatisfactory level of activity of public dental programs presently conducted indicates a definite need for special dental grant-in-aid funds to initiate the necessary expansion. This matter has been the subject of investigation by the Council on Dental Health of the Maryland State Dental Association. The findings, as follows, have been recognized by the association, which is on record as approving categorized Federal assistance for this purpose.

Maryland spends \$365,000 annually to maintain dental public health programs, including that administered as part of the medical care program for the indigent and medically indigent. This is 12 cents per capita and 2 percent of all public health expenditures in the State. These programs are grossly inadequate. As an example, in Baltimore City 15,000 school-age children annually receive dental care in school clinics and clinics for medical care recipients. It is estimated, however, that these children represent perhaps no more than 20 percent of the children of this city likely to belong to indigent and medically indigent families, and who consequently receive no care. Similar conditions obtain elsewhere in many parts of the State.

Too, there are sizable inadequacies in program administration, personnel training, preventive, diagnostic, and corrective dental services for preschool children and for adults, including the aged; also, in dental health education, and in the personnel and resources to engage in study and research.

To overcome these many deficiencies and to build an effective public dental program for Maryland, it is estimated that \$170,000 of additional funds would be required in the first year. This would be spent to obtain the services of new administrative and clinical personnel, expense money, and equipment to launch the needed expansion. In 5 years, at which time the expansion would be complete, the total bill for dental public health programs in Maryland would approximate \$1 million a year, three times the existent expenditure, of which \$635,000 would be funds additional to those available at this time from established sources.

There is little doubt that when increased funds are made available through State appropriations and matched through the device of a dental category in the Federal grant-in-aid program, Maryland will experience vastly improved dental health in every segment of the population.

I can assure you that many other States have similar figures. There is a great need now throughout the United States for State and local dental programs to put to work knowledge that already is available. Dental grants-in-aid would provide the basic springboard for breakthroughs in dental health measures.

For example, new dental programs for schoolchildren could be initiated and maintained on an incremental basis. By that I mean

not waiting until everything is decayed and let it fall out, but keeping up with the treatment as the defects are discovered.

Special studies concerned with early detection, referral and treatment of children with poorly aligned teeth, and children with malformed faces and jaws could be undertaken. Fluoridation of community water supplies, dental services for the handicapped of all ages, and studies that would concretely assist the dental profession—these advances and many more would result in benefits for all the people.

The American Public Health Association has long been concerned with the lack of the development of State and local dental programs. Recognizing the need for such support the American Public Health Association in 1956 adopted the following resolution:

Resolved, That the American Public Health Association go on record as approving and recommending categorical grant funds for dental public health programs, such funds to be used to support and strengthen basic dental public health services in State and local health departments and for special studies and investigations concerned with the dental public health problem and control measures; and be it further

Resolved, That copies of this resolution be sent to the American Dental Association; the Association of State and Territorial Dental Directors; the Secretary of the Department of Health, Education, and Welfare; the Surgeon General of the Public Health Service; and to the members of the House Appropriations Committee.

The officers and members of the American Public Health Association subscribe wholeheartedly to that view. We believe that oral health, as an integral part of total health, is essential to the optimum efficiency, morale, and economic vitality of people.

In behalf of the American Public Health Association, I urge enactment of S. 917.

The CHAIRMAN. Any questions, Senator Pell?

Senator PELL. No questions.

The CHAIRMAN. Doctor, you didn't have to come quite as far as some of our other witnesses, but we want you to know that we very much appreciate your presence here this morning and the statement that you have brought us. We thank you very much.

For inclusion in the record, I have a letter and statement in behalf of S. 917 which has been submitted by Dr. John A. Perkins, the president of the University of Delaware and formerly the Under Secretary of the Department of Health, Education, and Welfare during the administration of President Eisenhower. Dr. Perkins is unable to present oral testimony due to illness, but he is eminently qualified as a witness on the bill and served as chairman of the Commission on the Survey of Dentistry in the United States.

This commission was appointed by the American Council on Education in 1957 and financed by funds of the American Dental Association, the Kellogg Foundation, the Rockefeller Brothers Fund, and the Louis W. and Maud Hill Family Foundation. After a detailed and objective study of the status and needs of the dental profession in the United States, a final report was submitted in April 1960. The views of Dr. Perkins are based on his very careful study of dentistry during the chairmanship of the commission.

(The letter referred to follows:)

UNIVERSITY OF DELAWARE,
Newark, Del., May 22, 1962.

Senator LISTER HILL,
Committee on Labor and Public Welfare,
U.S. Senate, Washington, D.C.

DEAR SENATOR HILL: It is a matter of great personal regret to me that owing to illness I cannot be on hand May 24 for your hearings on Senate bill 917. I should like to have presented to you and your distinguished colleagues my support of S. 917.

My enthusiasm for the proposed legislation is owing to the steps this legislation would make toward implementing the report of the Commission on the Survey of Dentistry in the United States of which I was a member and chairman.

Would you, sir, include my prepared statement in the record of your hearings? I regret exceedingly not having the opportunity to exchange greetings and thoughts with you once again.

Sincerely yours,

JOHN A. PERKINS.

PREPARED STATEMENT OF JOHN A. PERKINS, PRESIDENT, UNIVERSITY OF DELAWARE

Mr. Chairman and members of the committee, I am John A. Perkins, president of the University of Delaware. I appear before you today, however, in my capacity as chairman of the Commission on the Survey of Dentistry to request the enactment of S. 917.

The Commission on the Survey of Dentistry was an independent body of professional and lay leaders appointed by the American Council on Education for the express purpose of conducting an objective study to determine how effectively this Nation is employing the resources at its command in assuring adequate standards of dental health and, further, to recommend methods for corrective action where improvement was deemed necessary. In fulfilling its purpose the commission had the continuing support and cooperation of the American Dental Association and other leading dental organizations.

From 1957, when the commission was appointed, until 1961, when our report, "The Survey of Dentistry," was published, the commission examined every facet of dental health, practice, education, and research. Nothing that came out of these investigations gives any of us, dentist or layman, the slightest excuse for complacency.

There is, first of all, this fact to be dealt with: Because the attack of dental diseases is nearly universal and because these diseases, once they begin to attack, can be controlled only through dental treatment, almost everyone requires the regular services of a dentist from early childhood onward. Yet in this country, in any given year, nearly 60 percent of the people fail to get any care at all.

Perhaps the most tragic victims of this massive neglect are children who are crippled and disfigured by diseases and conditions which might have been prevented and which could certainly have been controlled or corrected. But children are not the only sufferers, and for anyone to be deprived of dental service because he is ignorant of its value or too poor or too sick to seek it is an intolerable situation. Yet it is a situation which exists today, and one which may grow even worse tomorrow. For the truth is that the practice of dentistry is fast becoming a shortage occupation.

It is this coupling of a growing shortage of dentists and the Nation's manifest responsibility to increase personal utilization of dental services which creates much of the difficulty in providing answers to the dental health problem. Each of the 70 recommendations submitted by the Commission on the Survey of Dentistry was directed, in one way or another, toward achieving solutions which do not require the intensifying of one part of the problem in order to reduce another.

The commission considered it essential, first, that present dental schools be expanded and enough new schools be built to permit the graduation of at least 6,180 dentists a year by 1975, almost doubling current output, and that facilities also be provided for the training of sufficient numbers of auxiliary personnel. The commission recommended that Federal funds be provided, not only for expansion of school facilities, but for the operational expenses which will make it possible to avoid any loss of educational quality and for scholarships and loan funds which help schools attract the best qualified students.

While I consider passage of such legislation imperative, I consider it equally necessary to realize that far more than the perpetuation of a numerical status quo is going to be required of us.

The commission was convinced that one of the most effective things which can be done to overcome the grave disparity between needs and services is to reduce the occurrence of dental needs; that is, to institute and adequately support programs of disease prevention and control.

Believing that prevention begins with public education, the commission recommended that professional dental organizations and public health agencies at the National, State, and local levels expand dental health education. This must be accompanied by a greater effort by public agencies to promote active programs of prevention, and the commission urged that Federal grants-in-aid be made specifically for this purpose.

However, we shouldn't forget that similar efforts have been made by agencies in the past, and with something less than complete success. One reason for the failure has been the lack of studies which would give insight into the reasons people have for rejecting and ignoring important dental health measures. The commission, as a result, asked that research be broadened to include such studies and that dental schools participate in conducting them.

The commission believed, too, that a greater emphasis should be placed upon prevention in private practice and that changes in current methods of education are required to make this possible. We recommended that projects to evaluate the present curriculum be undertaken and that experiments in educational methods be conducted.

The fact remains, however, that not all disease can be prevented. Because it cannot, the next step essential to dental health is to see to it that needs which do occur are not compounded by continuing neglect. The commission recommended an allout effort to provide care to children as the best way to achieve this end. It called upon State and local communities to design and operate incremental care programs which will cover a new group of 6-year-olds each year until all 12 grades of school are included.

Families who can pay for such care should do so; care for children in indigent or low income families should be provided at State or local expense. The commission strongly recommended Federal assistance be given to support incremental care.

The commission was equally convinced that, as a Nation, we have a responsibility toward those people who are deprived of care because they are physically unable to seek it. We therefore urged the dental profession and the agencies of government to encourage and participate in the development of programs for disadvantaged groups such as the chronically ill and aged and handicapped children. Further, we considered it necessary for public agencies to cooperate with the profession in encouraging the development of prepaid dental care plans as a means of removing another formidable barrier to dental service—its cost.

These programs, together with others such as widescale epidemiological studies and improved training for public health, are all vital to the protection of dental health. They are designed to effect reductions in the ravages of disease and in the complications of neglect. They make possible a more economical and effective use of scarce manpower. And it should be noted that they are all programs requiring intelligent and well-focused support, planning, or administration by public health agencies at all levels of government. It is this last point in particular which makes the passage of S. 917 so important to the people of this country.

Throughout my term as chairman of the Commission on the Survey of Dentistry, I was continually impressed by the fact that so much of what needs to be done is dependent upon the effectiveness of public health agencies. By the same token, I was dismayed to discover that these agencies, particularly those at the State and local levels, have, as a rule, been forced to operate with undermanned staffs and totally inadequate budgets, and that Federal aid to dental programs has never approached a level commensurate with that provided to medical programs—undoubtedly a result of a lack of earmarked grants. It is, therefore, understandable that programs in education and prevention have floundered and that incremental care for children and home care for the ill and aged have seldom been attempted.

I joined with all other members of the Commission in recommending in our report that every effort be made by public and profession alike to obtain

more adequate financing for these dental programs, that a Federal grant-in-aid specifically designated for dental programs be made to States, and that agencies establish salary scales comparable to income in private practice, in order to attract and hold competent staff members.

I repeat that recommendation here today. S. 917, the bill now before this committee, provides the categorical grants which will make much of what needs to be done possible of achievement. It will give necessary financial strength to public health programs. Furthermore, by means of project grants to public and nonprofit agencies and institutions, this legislation will also contribute to the development of more adequate dental resources, since it will permit experiments in the content of education and demonstrations in the utilization of auxiliaries as a means of increasing the individual dentist's productivity. New methods of prevention can also be tested and demonstrated. Effective administrative procedures for group payment plans can be developed and taught. Dentists can be trained in the specialized techniques required to care for groups such as crippled children and the chronically ill. Community care programs for such groups can become an actuality.

As chairman of the Commission on the Survey of Dentistry, and on its behalf, I join the dental profession in urging the enactment of S. 917.

The CHAIRMAN. I also have a statement from the State and Territorial Health Officers Association and many letters and telegrams from State dental associations and departments of public health for inclusion in the record.

(The material referred to previously follows:)

STATE OF ALABAMA DEPARTMENT OF PUBLIC HEALTH,
Montgomery, Ala., May 22, 1962.

HON. LISTER HILL,
Senate Office Building, Washington, D.C.

DEAR SENATOR HILL: We understand that Senate bill 917 is to be brought up for hearing by the Subcommittee on Health of the Senate Committee on Labor and Public Welfare in the very near future. Please be assured that we are very much interested in the passage of this legislation as it will provide the methods of promoting sound dental public health programs over the Nation. The Alabama Dental Association's Committee on Legislation is in favor of this bill.

Dental disease is perhaps our most widespread and insidious disease inasmuch as so many people are afflicted and damaging effects are often not realized until it is too late for correction. We believe that with the passage of Senate bill 917 educational programs may be instituted so that key people in our public schools will have a basic understanding of the dental needs of our children. Also additional money will make possible the promotion of preventive dental programs as well as provide treatment for many of our truly indigent people. All of the educational and preventive measures will be designed not just for the indigent population but for all of our people. In addition plans must be made for meeting the dental needs of our aged population. To date we have been unable to promote a program of this type due to lack of funds.

We are enclosing a copy of our proposed expansion in the event additional funds are made available through the passage of this grant-in-aid legislation.

We would certainly like to thank you for the fine work you have done in the field of health. You have helped make possible adequate medical care to many of our people who otherwise would not have been able to afford it. The Hill-Burton hospital facilities over our State are a joy to see and it has been my experience to observe that they are being used to the utmost in Alabama. Our new county health centers made possible through Hill-Burton funds are doing excellent jobs in the field of public health. Virtually all of these centers have or have space for dental clinics. We have one or more active dental clinics in 28 of our 67 counties. These clinics are providing excellent service to many of our indigent people.

Thank you again for your dedication and devotion to the American people regarding health and other matters.

Sincerely yours,

JOHN M. ARNOLD, D.M.D.,
Acting Director, Bureau of Dental Hygiene.

ARIZONA STATE DENTAL ASSOCIATION,
Phoenix, Ariz., May 23, 1962.

Senator LISTER HILL,
Senate Office Building, Washington, D.C.

DEAR SENATOR HILL: The American Dental Association has asked each State society to mail to you its past resolutions concerning S. 917, pending now before your Committee on Labor and Public Welfare.

Arizona dentists oppose this legislation because of its lack of limitations as to the extent of the dental programs it would authorize. This does not mean that we are opposed to any and all dental public health programs, but dental health and education legislation that includes the possibility of unlimited treatment programs is not proper or indicated.

With all due respect to your position in this matter, I urge that you give these thoughts your careful consideration.

Sincerely,

R. L. KOERNER, D.D.S.,
Chairman, Legislative Committee.

ARIZONA STATE DENTAL ASSOCIATION RESOLUTION—FEDERAL GRANTS-IN-AID FOR
DENTAL PUBLIC HEALTH

The house of delegates of the American Dental Association voted in 1952 (Trans. 1952: 182) and again in 1956 (Trans. 1956:123) to support Federal aid to the States for dental public health purposes under the Public Health Service Act. Arizona concurred in the unanimous vote on both occasions. However, on April 14, 1961, after careful review of the present bills, S. 917 and H.R. 4742, relating to "the prevention and control of dental diseases and for other purposes," the Arizona State Dental Association's house of delegates voted to oppose the bill.

Since 1952 we have become increasingly concerned with the growth of Federal aid and controls as applied to the health professions. Previous grant-in-aid bills have applied to specific illnesses and communicable diseases. These constitute a small segment of the practice of medicine. S. 917 and H.R. 4742, which provides for "the prevention and control of dental diseases and for other purposes," will encompass the practice of dentistry and nowhere does it limit treatment programs. The treatment programs intended by this bill have been alluded to by our American Dental Association Council on Legislation as follows: "Of urgency in this area are needs for providing methods of making dental care available to handicapped children, the aged, the chronically ill and other institutionalized or homebound persons * * * dental care to people in remote or rural areas."

The Arizona State Dental Association believes it has not been diligent enough in the past in providing help and guidance in the field of dental public health and proposes to use its knowledge and leadership in helping establish an adequate dental health program within the confines of our local government and urges other State societies to take similar action: Therefore be it

Resolved, That Federal grant-in-aid funds for the "prevention and control of dental diseases and for other purposes" as stated in S. 917 and H.R. 4742 be disapproved.

[Telegram]

CLARKSVILLE, ARK., *May 23, 1962.*

HON. LISTER HILL,
Senate Office Building, Washington, D.C.:

The Arkansas State Dental Association has gone on record as supporting the principle of Federal matching grants for State public dental health programs as provided in S. 917. We wish to reaffirm our position in this matter and respectfully urge that this much needed measure receive early passage.

DON M. HAMM, D.D.S.,
Secretary-Treasurer, Arkansas State Dental Association.

STATE OF CALIFORNIA DEPARTMENT OF PUBLIC HEALTH,
Berkeley, Calif., May 21, 1962.

Hon. LISTER HILL,
Chairman, Senate Committee on Labor and Public Welfare, Senate Office
Building, Washington, D.C.

MY DEAR SENATOR HILL: It has come to my attention that a hearing of S. 917 is to be held May 24, 1962, by the Committee on Labor and Public Welfare, and I wish to emphasize the urgency for early passage of this excellent bill establishing a grant-in-aid program for the prevention and control of dental diseases.

Grant-in-aid programs for health purposes were initiated in 1935; as a result, great progress has been made in disease prevention and health improvement benefiting all people directly and indirectly. Due to such assistance, public health in California and across the Nation was stimulated and enabled to develop and expand programs at the State and local level which have markedly reduced the prevalence of communicable diseases and protected and improved the health of the people. The list of accomplishments is long and impressive, clearly demonstrating that when State and local disease-prevention and health-improvement programs are adequately financed, to permit operation on a broad scope and over a sufficient period of time, definite and lasting health benefits are achieved.

Yet, today, dental diseases remain at epidemic proportions in our population. They rarely are fatal, it is true, but they do cause untold suffering, much loss of productive time and, because in a large measure they can be prevented, cause an unnecessary economic burden on the people. Dental public health has received relatively meager and sadly inadequate financial assistance at State and local levels and has not to date been provided the consideration and assistance of a categorical grant-in-aid program. It is urgently needed.

The following facts from only one State, California, demonstrate the magnitude of accumulated dental disease in the population (estimated figures):

Decayed teeth, untreated.....	45, 800, 000
Teeth missing due to disease.....	120, 300, 000
Children and adults suffering periodontal disease.....	8, 048, 000
Children with orthodontic defects.....	2, 039, 000
Babies born crippled by cleft palate or lip, 1961.....	4, 600
Cases of oral cancer—546 deaths—1960.....	2, 014

This is the picture of dental disease in California's population. Much of it could be prevented.

The economic burden is equally stupendous, shown by these estimates: The people in California who obtain dental treatment (about 50 percent of the total population) expend annually approximately \$326 million. This represents the demand for dental care. However, if the total dental needs of California's nearly 17 million population were to be met today, more than \$6 billion would be needed. Even if \$6 billion were available, there are just 9,229 dentists in active practice. Treatment alone is not a feasible solution.

The prevention of dental disease is the most practical and economical approach to the alleviation of this tremendous health problem. Yet in California only \$85,000 are appropriated at State level for dental public health programs for prevention. Although California's population has steadily increased in the last 13 years, there has been no increase in staff personnel or program budget of the division of dental health, State department of public health, to cope with the ever-increasing dental health problems of the population. Added to this deficiency, there has been no increase in financial assistance for dental public health program development at the local level in the last decade. Only 8 local health departments out of 79 health jurisdictions have a budgeted and directed dental public health program. The same deficiencies exist in most of the other States.

The magnitude of the dental disease problem, the economic burden, the gross deficiency in financial support of preventive programs at State and local level have been delineated. On the other hand, the dental public health profession has the technical and scientific knowledge, the experience and the administrative ability to design, develop, and conduct programs for the prevention of dental diseases and to provide leadership in assisting the people to achieve and maintain their dental health at as high a level as possible. Dental public health within the limits of personnel and financial support has made much progress in the field

of prevention. Much more needs to be done. Much more can be done in preventing dental disease in children and adults, in the handicapped, and chronically ill, and the aged if adequate financial support is made available at State and local levels. S. 917 would provide the financial support needed to adequately assist local health departments, schools, and communities in the development and conduct of dental disease prevention programs for the people.

Dental diseases are for the most part insidious in onset and sequelae. Consequently, there exists a definite predilection toward appropriating available financial support for the alleviation of diseases that are more dramatically severe in attack and results. This places dental public health at a serious disadvantage in competing with other health programs for its share of the health dollar. Categorical grant funds are essential if this problem is to be remedied.

A cooperative Federal-State grant-in-aid program for the prevention and control of dental diseases is urgently needed. It is a time-tested, practical method to assist in providing vitally needed support. Such a cooperative program is embodied in S. 917.

The California State Department of Public Health respectfully urges the early passage of S. 917, which will provide immeasurable benefit to the young, the aged, the poor, the handicapped and chronically ill—to all people, since all are affected by dental diseases.

It will be greatly appreciated if this letter is placed in the record of the hearing on S.917.

Very sincerely yours.

MALCOLM H. MERRILL, M.D.,
Director of Public Health.
 By HAROLD M. ERICKSON, M.D.,
Deputy Director.

CITY OF SAN JOSE, CALIF.,
 May 18, 1962.

Senator LISTER HILL,
Chairman, Committee on Labor and Public Welfare,
Senate Office Building, Washington, D.C.

MY DEAR SENATOR HILL: I am writing this letter in support of Senate bill 917, which I understand will be heard on May 24, 1962. I understand that this bill will amend the Public Health Services Act to establish categorical grants in dental public health to provide matching funds to the States for the prevention and control of dental disease and that it will include funds for demonstration purposes and training of personnel in the field of dental health.

The California Conference of Local Health Officers, whose membership includes all of the health officers in the State of California, wishes to express their great interest in the passage of this bill. Dental disease is one of the most common afflictions of children in this State. Our facilities to prevent dental disease and research into the best methods of preventing dental disease are urgently in need of assistance and support. The shortage of dental hygienists and dental health educators has reached the point where it is almost impossible to secure replacements to fill vacant positions. Funds for training people in these fields are needed greatly. We also have many transient children whose parents are working in the crops traveling from one State to another and consequently lack dental care or dental health education.

I am sure there are several health departments who would be willing to engage in experimental demonstration procedures to assist in the solution of this nationwide problem. Without Federal financial assistance, I feel that it will be many years before either this State or local health departments will be able to carry out this kind of investigation and training procedures.

May I urge the committee's approval of Senate bill 917.

Respectfully submitted.

D. M. BISSELL, M.D.,
President, California Conference of Local Health Officers.

STATE OF COLORADO DEPARTMENT OF PUBLIC HEALTH,
Denver, Colo., May 21, 1962.

Senator LISTER HILL,
*Chairman, Committee on Labor and Public Welfare,
 U.S. Senate, Washington, D.C.*

DEAR SENATOR HILL: I am writing to urge you to support S. 917 regarding Federal grants-in-aid in support of dental public health. In Colorado our need for earmarked funds for dental health activities is great as our dental staff is grossly inadequate to meet the dental public health needs of the citizens of the State. One of the major problems in Colorado is the fact that we have no dental school in the entire Rocky Mountain area. Consequently we have had a shortage of dentists and dental hygienists in many areas of the State. This has resulted in many individuals in the State not receiving needed dental care because of distances and time involved. Therefore, it is of extreme importance that all known dental preventive practices be employed. The adoption of legislation of this type would enable the Public Health Dentistry Section of the Colorado State Department of Public Health to expand its present programs as well as to initiate others. To give you some idea of the type of services and programs that would be expanded or initiated, we have listed the following:

1. Give greater assistance to communities in developing and carrying out programs for the fluoridation of their water supplies.
2. Develop programs that would prove practical for home fluoridation projects in areas not served by community water supplies.
3. Expand and develop new dental clinics in local health departments, particularly for children whose parents cannot afford dental care.
4. Develop programs for providing dental care for individuals suffering from chronic illness, particularly the homebound and those confined to nursing homes and unable to get to a dental office.
5. Health education activities greatly expanded, particularly for teachers in preparing them to present appropriate dental health facts.
6. Develop programs for provision of dental service to special population groups such as migrants.
7. Carry out studies and investigations designed to yield more information about the nature and extent of dental diseases in the population of the State.
8. Develop postgraduate refresher courses for the dental profession in oral cancer detection, dental techniques for the treatment of the chronically ill, dentistry for children and the use of ancillary personnel.

I urge you to support this much-needed legislation that will materially benefit the citizens of Colorado.

Sincerely yours,

ROBT A. DOWNS, D.D.S., M.S.P.H.,
Chief, Public Health Dentistry Section.

COLORADO DENTAL ASSOCIATION,
June 1, 1962.

Senator LISTER HILL,
*Chairman, Committee on Labor and Public Welfare,
 U.S. Senate, Washington, D.C.*

DEAR SENATOR HILL: We are writing to you to urge you to support S. 917 regarding Federal grants-in-aid in support of dental public health. The following resolution was passed at the annual meeting of the Colorado State Dental Association on October 4, 1960.

"Whereas the Colorado State Dental Association has studied National and Colorado reports of the dental needs of the public and the importance of preventing and controlling dental diseases and handicapping dental conditions; and

"Whereas effective measures are available to prevent and alleviate many of these conditions; and

"Whereas these measures are not being utilized fully by dental units in State health departments because of inadequate financial support of dental programs; and

"Whereas, Federal grants-in-aid are well established as an effective means of supporting State health programs in combating diseases without impairing the rights of States and communities to determine and administer their own programs: Be it therefore

"Resolved, That the Colorado State Dental Association strongly recommends Federal categorical grant funds for the supporting and strengthening of dental public health services in State and local health departments; and be it further

"Resolved, That the Colorado State Dental Association actively support appropriate legislative efforts to this end."

Thank you for your assistance.

Respectfully yours,

GEORGE H. SIERSMA, D.D.S., *Secretary.*

[Telegram]

HARTFORD, CONN., *May 25, 1962.*

Senator LISTER HILL,
*Committee on Labor and Public Welfare,
U.S. Senate Office Building,
Washington, D.C.:*

As a private dental practitioner school dentist and participant in Hartford's Health Department program I keenly recognize the urgent need for specific funds to be earmarked for dental health. May I urge a favorable committee report on S. 917 grants-in-aid for dental public health. Request this message be included in minutes of committee proceedings.

JACK OPINSKY, D.D.S.

[Telegram]

HARTFORD, CONN., *May 24, 1962.*

Hon. LISTER HILL,
*Chairman, Committee on Labor and Public Welfare,
Senate Office Building,
Washington, D.C.:*

Urge support for S. 917, grants-in-aid for dental public health. The dental health of our people has been neglected to the point where the Nation's health suffers as a result. Categorical grants for this purpose are urgently needed. Request this message be included in the records of your committee hearings.

ALFRED L. BURGDORF, M.D.,
Director of Health, City of Hartford, Conn.

DELAWARE STATE DENTAL SOCIETY,
Wilmington, Del., May 22, 1962.

SENATE HEARING COMMITTEE,
Dover, Del.

GENTLEMEN: The president, executive council, and membership of the Delaware State Dental Society wish to inform the Delaware State Legislature of its wholehearted support and agreement with Senate bill 917. This grants-in-aid bill, sponsored by the Commission on Labor and Public Welfare and introduced by Senator Lister Hill, will have a Senate committee hearing on Thursday, May 24. It is the request of the Delaware State Dental Society that this letter of endorsement might be read into the minutes of the Senate committee hearing.

Yours truly,

GARRETT B. LYONS,
Chairman, Legislative Council.

DELAWARE STATE BOARD OF HEALTH,
Dover, Del., May 21, 1962.

Hon. LISTER HILL,
Senate Office Building, Washington, D.C.

DEAR SENATOR HILL: The bill which you introduced to provide for dental grants-in-aid (S. 917) offers assistance much needed to all States. In my own State our dental program is tremendously handicapped due to lack of personnel which in some instances are not available due to budget limitations.

Surveys made here in recent years indicate that dental diseases rank first among physical defects found among preschool children and children of school age; that less than 35 percent of the children enrolled in our schools are receiving adequate dental care. Our present activities are inadequate to meet our needs.

Your efforts to obtain dental grants-in-aid is truly appreciated and I would like for this letter to be read into the records of the committee meeting.

Yours sincerely,

(Miss) MARGARET H. JEFFREYS,
Director, Division of Oral Hygiene.

FLORIDA STATE BOARD OF HEALTH,
Jacksonville, May 22, 1962.

HON. LISTER HILL,
*Chairman, Committee on Labor and Public Welfare,
U.S. Senate, Washington, D.C.*

DEAR SENATOR HILL: As director of the Bureau of Dental Health for the Florida State Board of Health during the past 12 years I have been able to plan and conduct mass dental surveys and studies to determine the dental needs of children, the aged confined to nursing homes, and for the chronically ill confined to homes or hospitals.

Our bureau has also surveyed presently available facilities and sources of funds to meet the needs for establishing sound dental health preventive educational projects and to render dental care for young children whose parents cannot send their children to the office of the private dentist for needed treatment.

Because 95 percent of our children need some type of dental care and in view of the fact that statistics established by the U.S. Public Health Service show that 22 million adults in the United States have lost all of their teeth, it becomes a vast public health problem. Therefore, it deserves to be treated as such and, on the basis as other diseases, such as mental health, cancer control, and other illnesses, many of which now receive specially designated funds for programs of education and control.

In Florida, as in many other States, we are severely handicapped and our progress is hindered because of lack of funds diverted directly to the expansion of dental public health. We think such funds should be made available at an early date.

The bureau of dental health has discussed at great length with the Florida State Dental Society, Senate bill 917, which you introduced in an attempt to alleviate the financial conditions under which dental public health now operates. The executive council of the Florida State Dental Society has approved and officially endorsed this bill. We trust this legislation will be favorably acted upon at this session of Congress. We appreciate very much your efforts in behalf of this bill and other public health legislation which you have sponsored.

It is hoped that this letter will be included in the records of the hearing on this bill.

Sincerely yours,

FLOYD H. DECAMP, D.D.S., *Director.*

RESOLUTION OF FLORIDA STATE DENTAL SOCIETY

Whereas the Florida State Dental Society endorses the philosophy which led to the writing of S. 917; and

Whereas the Florida State Dental Society is acutely aware of the needs of such legislation as S. 917; and

Whereas the Florida State Dental Society fully intends to support legislation which will lead to better dental health for all the people and will aid in implementation of such legislation and will cooperate as private practitioners of dentistry in areas in which our cooperation is desired; and

Whereas the Florida State Dental Society feels that S. 917 is a definite step forward in providing dental care and education in those areas in which there is great need; however, the Florida State Dental Society solemnly holds that the incorporation of the principles of dental services and education of peoples as outlined in the following paragraph would serve to strengthen S. 917 by clarifying the full intent of the measure to all concerned in its administration and would further insure that the bulk of the funds appropriated would be spent in those areas in which the need is most acute; that is, dental services and treatment for the institutionalized, the homebound elderly, inhabitants of nursing homes, indigent children, and other classifications as set forth in the following paragraphs: Therefore, be it

Resolved, That the executive council and the Florida State Dental Society, at its 79th annual meeting, approve S. 917 with the following provisions:

1. The kinds of dental public health services should be defined as such recognized activities as dental health education, fluoridation of community water supplies and demonstrations of topical fluoride application. The public at large would be the beneficiaries of these kinds of activities.

2. The persons for whom the treatment is intended should be those in especially difficult circumstances such as the physically handicapped, institutionalized patients, and the homebound elderly. The public health dentist and his staff would be interested mainly in the planning of programs for bringing care to institutionalized patients, for example, or the elderly homebound. It would be expected that the treatment and care would be provided by private practitioners insofar as possible.

3. The training courses for dentists should be designed mainly to train privately practicing dentists in methods best adapted to care for the chronically ill, handicapped children, or homebound elderly.

4. It is important that S. 917 will not compel any State dental association to follow a specific pattern in developing its dental public health program. If the State of Florida, for example, wishes to expand its program for providing dental care to indigent persons, some support from S. 917 would be available for that kind of program.

* * * * *

Presented to the general assembly of the Florida State Dental Society at its 79th annual meeting in Hollywood, Monday, May 14, 1962.

GEORGIA DENTAL ASSOCIATION,
Macon, Ga., May 22, 1962.

HON. LISTER HILL,

*Chairman, Senate Committee on Labor and Public Welfare,
Senate Office Building, Washington, D.C.*

DEAR MR. HILL: The members of the Georgia Dental Association wish to reaffirm their support of Senate bill 917 as we understand the Senate Committee on Labor and Public Welfare will begin hearings on this bill on Thursday, May 24, 1962.

For your information and ready reference, I am attaching copy of my letter to you dated January 24, 1962, regarding our endorsement of S. 917.

Sincerely yours,

JAMES L. CASSIDY, D.D.S.,
Secretary-Treasurer.

GEORGIA DENTAL ASSOCIATION,
Macon, Ga., January 24, 1962.

HON. LISTER HILL,
*Senate Building,
Washington, D.C.*

DEAR MR. HILL: The members of the Georgia Dental Association strongly endorse the passage of H.R. 4742 and S. 917, introduced at the last session of Congress, which provides grant-in-aid funds earmarked for State dental public health programs.

This proposed legislation's purpose is to place dental programs on an equal footing with other public health programs on the State level and to provide financial support for dental educational projects and studies of dental health problems, including those of the aged and chronically ill, homebound, institutionalized persons and handicapped children.

If this legislation is passed, it will also help strengthen the State dental public health departments by permitting additional professional and staff personnel. We, therefore, urge you to vote in favor of H.R. 4742 and S. 917 when this legislation comes up for vote.

Sincerely yours,

JAMES L. CASSIDY, D.D.S.,
Secretary-Treasurer.

STATE OF GEORGIA, DEPARTMENT OF HEALTH,
Atlanta, Ga., May 22, 1962.

HON. LISTER HILL,
*Senate Office Building,
 Washington, D.C.*

DEAR SENATOR HILL: I am writing to support in principle S. 917, an amendment to section 314 of the Public Health Service Act.

Additional funds are needed to fully develop programs of dental public health services of both formula and project grant mechanism would be very effective in promoting such development.

I indicate approval in principle because I would very much like to see any grants developed under such legislation come to or through State health departments rather than as in the only copy of S. 917 I have being available to other agencies without involvement of State health departments.

I would appreciate your consideration of this problem and will certainly want you to use our support in any way you see fit in the upcoming hearing on this bill.

With best personal regards, I am,

Sincerely yours,

JOHN H. VENABLE, M.D., *Director.*

STATE OF ILLINOIS DEPARTMENT OF PUBLIC HEALTH,
Springfield, May 24, 1962.

HON. LISTER HILL,
*U.S. Senate,
 Washington, D.C.*

DEAR SENATOR HILL: This will call your attention to Senate bill 917 which was introduced on February 13, 1961, and is now pending before the Senate Committee on Labor and Public Welfare.

The bill provides for a grant-in-aid program which would made Federal funds available to States on a matching basis for the prevention and control of dental diseases.

The Illinois Department of Public Health recognizes the importance of educational and preventive programs, but also realizes that professional dental care must be available if an educational program is to be successful.

Through cooperative arrangements with a limited number of full-time county health departments, demonstration programs on the importance and effectiveness of dental care have been initiated. Although such programs are needed in county health departments throughout the State, the costs require that they be limited both in number and possible duration.

A cooperative Federal-State program of grants-in-aid would stimulate the initiation of more programs and would help provide a practical solution to many dental health problems in Illinois. It would be appreciated if this letter could be made a part of your committee's record.

Yours sincerely,

FRANKLIN D. YODER, M.D.,
Director of Public Health.

STATE OF ILLINOIS DEPARTMENT OF PUBLIC HEALTH,
 DIVISION OF DENTAL HEALTH,
Springfield, May 24, 1962.

HON. PAUL H. DOUGLAS,
*U.S. Senate,
 Washington, D.C.*

DEAR SENATOR DOUGLAS: This will call your attention to Senate bill 917 which is now pending before the Senate Committee on Labor and Public Welfare.

The bill provides for a grant-in-aid program which would make Federal funds available to States on a matching basis for the prevention and control of dental diseases.

Under existing law, Federal matching funds granted to States for specified medical programs have helped make those programs successful. The need is just as great to strengthen dental public health programs.

A cooperative Federal-State program of grants-in-aid would make possible the initiation of more dental programs and help provide a practical solution to many dental health problems in Illinois.

With 25 years experience in the Illinois Department of Public Health as a dental consultant; as chief of the bureau of dental research and now as acting chief of the division of dental health, the need for Federal matching funds seems obvious to me.

Sincerely yours,

ORVIS S. HOAG, D.D.S., *Acting Chief.*

FEBRUARY 24, 1961.

HON. BARRATT O'HARA,
*U.S. House of Representatives,
Washington, D.C.*

DEAR SIR: The members of the Illinois State Dental Society, being concerned over the dental health of the public and knowing of the lack of complete dental care, prevention, and control of dental diseases, present the enclosed resolution for your consideration.

Sincerely yours,

PAUL W. CLOPPER, D.D.S., *Secretary.*

RESOLUTION FROM ILLINOIS STATE DENTAL SOCIETY REGARDING CATEGORICAL
GRANTS FOR DENTAL HEALTH

Whereas the prevention and control of dental diseases are becoming of greater urgency due to the lack of adequate dental health education and facilities because the funds and personnel of the Illinois Department of Public Health, Division of Dental Health, are inadequate to provide or assist in providing these necessary services throughout the State; and

Whereas the council on dental health of the Illinois State Dental Society recognizes that there are some areas of the State which are economically depressed; and

Whereas the council on dental health of the Illinois State Dental Society deems it wise to expand the department's activities of education, prevention, and control of dental diseases to cover each county of the State of Illinois: Therefore, be it

Resolved, That the executive council of the Illinois State Dental Society urges the Senators and Representatives in Congress from Illinois to support the bill introduced by Senator Lister Hill, namely S. 3780, which deals with categorical grants on dental health to States.

INDIANA STATE DENTAL ASSOCIATION,
Indianapolis, Ind., May 25, 1962.

Senator LISTER HILL,
*Chairman, Senate Committee on Labor and Public Welfare, Senate Building,
Washington, D.C.*

DEAR SENATOR HILL: I realize this letter will arrive no doubt after your committee has conducted hearings on S. 917, but we have just completed the 104th annual meeting of the Indiana State Dental Association, and time did not allow me to write you earlier this week.

I wish to speak in support of dental categorical grant-in-aid funds similar to the funds that have supported and strengthened medicine's attempt to improve the health of the people of this country through the various public health programs such as heart, cancer, tuberculosis, and etc. I spent 15 years working in dental public health, and am quite proud of dentistry's beginning in the general direction of improving the dental health of the citizens of Indiana. However, I know from personal experience that we could not have had a dental public health program in Indiana without the cooperation and support of the children's bureau and the maternal child hygiene director in Indiana. It was only through their generosity and interest in dental health that we were able to obtain funds to support our activities. I know that dental earmarked funds would allow the Dental Division of the Indiana State Board of Health to strengthen its present programs of dental health education, clinical research and community demonstration projects, and no doubt would allow a modest ex-

pansion of some of these activities and that these activities would have the support of the dental profession in Indiana. Therefore, I respectfully urge you to lend your support to this kind of legislation which will allow program determination and administration at the State and community level.

Respectfully,

CHARLES L. HOWELL, D.D.S.,
Secretary.

IOWA DENTAL ASSOCIATION,
Des Moines, Iowa, June 1, 1961.

HON. LISTER HILL,
Senate Office Building, Washington, D.C.

DEAR SENATOR HILL: At the annual session of the Iowa Dental Association May 2, 1961, a resolution was approved pertaining to grants in support of dental programs in State departments of health. A copy of the resolution is enclosed.

We urgently solicit your support for this legislation which we feel is in the public interest.

With all best wishes, I remain

Sincerely,

HOMER N. HAKE, D.D.S., *Secretary.*

IOWA STATE DEPARTMENT OF HEALTH RESOLUTION

Whereas a bill has been introduced in the Congress of the United States for grants in support of dental programs in State departments of health known as S.F. 917 and H.R. 4742; and

Whereas there is great need for expansion of the program of the Division of Dental Hygiene of the Iowa State Department of Health; and

Whereas the Iowa Legislature only appropriates \$4,500 annually for the program of the division which must be supplemented by Federal funds in support of the division; and

Whereas dentistry is in a very unfavorable position to compete for funds in most State health departments. Dentistry frequently has a relatively low priority when compared with medical programs and many of the medical programs also have access to earmarked Federal grants, while dentistry does not. Consequently, dental health programs are at a double disadvantage; and

Whereas there are still over 400 Iowa communities that need to supplement their water supply with fluorides, more funds are needed for additional personnel for promotion; and

Whereas there are 13 percent of the rural schools, 19 percent of town schools, and 45 percent of parochial schools not participating in the Iowa plan for dental education, more funds are needed for additional personnel to promote the plan; and

Whereas there is need for personnel to participate in teacher training course on the subject of dental health education; and

Whereas there is need of funds to promote more facilities in the State of Iowa for dental care of dentally indigent children and aging: Therefore, be it

Resolved, That the House of Delegates of the Iowa Dental Association approve this legislation and urge the Congress to support categorical grants to dental programs in State health departments; and be it further

Resolved, That copies of this resolution be sent to Senator Lister Hill and the Senators and Representatives of Congress from the State of Iowa by the secretary.

IOWA STATE DEPARTMENT OF HEALTH,
Des Moines, Iowa, July 25, 1961.

HON. LISTER HILL,
U.S. Senator, Senate Office Building, Washington, D.C.

DEAR SENATOR HILL: Please let me express my appreciation for your interest in dental health. We dentists who work in public health realize the great need for prevention and control of dental diseases and the bill you introduced, S. 917, will make possible greater effort in solving these problems.

In Iowa, as in other States, practically 100 percent of the population will at some time in their lives, suffer from oral diseases. Preventive measures to reduce this condition are available. To reach the people with these preventive measures takes personnel and money.

Studies made in Iowa communities where fluoride ion has been added to their water supply show that dental caries incidence can be reduced by at least 60 percent. There are still 430 communities in Iowa that need to supplement the fluoride ion in their water supplies to the optimum concentration. (See pages 2, 3, and 4 of enclosed booklet.)

Dental care facilities for the care of children whose parents cannot afford such service should be promoted.

Dental care for the chronically ill and aged needs to be studied and methods of furnishing such care provided.

These are only three of the many programs that need immediate promotion in Iowa.

Since 1927 an excellent dental health education program has been active in Iowa. In the school year of 1959-60 it was used in the rural schools of 92 of our 99 counties, in 569 town public schools and 168 parochial schools. There are many schools in our State that need to be reached with the program. Additional personnel is needed.

Enclosed is a copy of the 1959-60 report of the program of dental health education in Iowa schools. The passage of S. 917 will mean much to the dental health of the people of Iowa.

Heartily yours,

CHARLES H. HENSHAW, D.D.S.,
Director, Division of Dental Hygiene.

[Telegram]

KANSAS CITY, KANS., May 23, 1962.

Senator LISTER HILL,
*Chairman, Senate Committee on Labor and Public Welfare,
Senate Chamber, Washington, D.C.:*

The Kansas State Dental Association strongly recommends the passage of Senate bill 917 a bill to provide matching grants for State public health programs. Your cooperation and help in securing passage of this bill will be greatly appreciated.

FRED A. RICHMOND, D.D.S.,
Secretary, Kansas State Dental Association.

THE KANSAS STATE BOARD OF HEALTH,
Topeka, Kans., May 24, 1962.

Hon. LISTER HILL,
U.S. Senate, Washington, D.C.

DEAR SENATOR HILL: Enclosed are copies of the letters I have sent to our Kansas Senators, Frank Carlson and James B. Pearson.

We trust that favorable consideration may be given this important and greatly needed health legislation.

Yours sincerely,

WILLARD R. BELLINGER, D.D.S., M.P.H.,
Director, Division of Dental Hygiene.

THE KANSAS STATE BOARD OF HEALTH,
Topeka, Kans., May 22, 1962.

DEAR SENATOR: It is a pleasure to send greetings to you from Kansas. We are most mindful and very grateful to you for your great and successful record of service to the citizens of Kansas.

This letter is being written to you regarding bill S. 917, the passage of which will mean so much to the health of the present and future citizens of Kansas. It is my understanding that the bill will be coming up for hearings, Thursday, May 24.

As you know, for many years there have been grants-in-aid for cancer, venereal disease, tuberculosis, heart disease, mental health, and maternal and child health care. The primary purpose of this legislation is to provide for a simi-

lar categorical grants-in-aid program for the prevention and control of dental diseases. The bill provides for Federal funds to States on a matching basis to be used specifically for public health programs designed to control and prevent dental diseases.

The problem of dental decay, particularly in the teeth of children, is staggering and the problem will continue to become worse as the ratio of population to dentists continues to become greater with the expanding growth in population due to the increasing birth rate. Recently there has been a modest increase in the number of dentists who are graduating yearly from this country's dental schools. However, the greatest hope for dental health in the foreseeable future lies not in the additional dental graduates yearly, but in the control and prevention of dental diseases through community dental public health programs.

With the more recent program of fluoridation of public water supplies, having a potential for reducing up to 60 percent the rate of dental decay in children's teeth, and resulting in a long-range benefit to the dental health of the aging group of the future, concern with the present dental health needs of the aged and aging, involvement in radiologic health, maintaining the established statewide school dental health program which reaches and assists practically every family with children in the State, the annual statewide observance of National Children's Dental Health Week, the consideration of the dental needs of the handicapped children, those with cerebral palsy, the epileptic, cleft-lip and palate and those with severe malocclusion, and other vital dental public health programs, the director of the division of dental hygiene, without administrative assistance and field representatives, finds that a most critical problem has developed in maintaining previously established programs and planning for effective administration of new programs, the demands for which continue to increase.

It is most frustrating for a State dental director to know that many thousands of permanent teeth yearly are being sacrificed unnecessarily among our Kansas children only because the division director alone and with inadequate funds cannot possibly provide the local assistance needed among the 300 cities in Kansas with fluoride-deficient public water supplies. However, I hasten to add that Kansas ranks high among the States in this region in the number of cities served with controlled fluoridation. As of this date, 39 cities in Kansas have made the fluoride adjustment in the public water supplies, involving a total population of approximately 407,000 people. Dr. Carl J. Whitney, of Concordia, whom I am sure you know, and who recently was elected president of the Kansas State Dental Association, recently made inquiry regarding the fluoride adjustment of the Concordia fluoride-deficient public water supply. With additional professional personnel and adequate funds the various programs could move along much faster, meeting more adequately the ever-increasing problem of "dental sickness" so prevalent among children and youth.

It seems to take a war to emphasize the size and scope of the dental health problems. Early during World War II dental disease and deficiencies constituted the largest single cause of rejections (20 percent) among the inductees examined for military service. When one of every five of our country's young people is rejected by the armed services because of dental disease and deficiencies, a major crisis has arisen and one which deserves major consideration. It is believed that the only practical approach to the solution of the dental health problems lies in a cooperative Federal-State program.

The proposed program of Federal grants-in-aid to States in support of State dental programs has the support of the Kansas State Dental Association. For verification of the association's stand on this issue, I invite you to contact our good mutual friend, Dr. Fred A. Richmond, secretary, Kansas State Dental Association, 861 Brotherhood Building, Kansas City, Kans.

Your thoughtful and considerate appraisal of the above stated vital factors as related to the health needs in Kansas will be greatly appreciated. We trust that favorable action will be taken on this very important and greatly needed health legislation which comes up for hearings, Thursday, May 24. I apologize for the length of this letter. However, without at least providing a brief explanation, I did not feel justified in seeking your support on S. 917.

Best wishes to you.

Yours sincerely,

WILLARD R. BELLINGER, D.D.S., M.P.H.,
Director, Division of Dental Hygiene.

[Telegram]

LOUISVILLE, KY., May 18, 1962.

Senator LISTER HILL,
Senate Office Building, Washington, D.C.:

The Kentucky Dental Association urges the committee to give favorable support to S. 917 categorical branch in aid for State dental health program.

DR. A. B. COXWELL,
Secretary, Kentucky Dental Association.

PROGRAM OF KENTUCKY DENTAL ASSOCIATION FOR PREVENTION AND CONTROL OF
DENTAL DISEASE

Resolution for consideration by the executive board and the house of delegates of the Kentucky Dental Association pertaining to a bill introduced by Senator Lister Hill (S. 3780) to establish a dental category in the Federal grants-in-aid programs for State public health activities

Whereas Senator Lister Hill has introduced a bill (S. 3780) to establish a dental category in the program of Federal grants-in-aid to States for general health activities; and

Whereas this is in accordance with the policy adopted by the American Dental Association's House of Delegates in 1952; and

Whereas the grants-in-aid principle has been used for more than 40 years to assist State and local governments to expand, develop, and improve existing health programs; Federal funds earmarked for specific areas such as heart disease, cancer, tuberculosis, maternal and child health, have served as a potent stimulus to develop effective programs; similar results can be achieved in the area of dental disease by the establishment of a dental category; and

Whereas there is a definite need for an informed public, with an appreciation of and a motivation for good dental health, better trained personnel, availability of dental care to all segments of the population, and research to eliminate dental disease; therefore be it

Resolved, That the Kentucky Dental Association by action of its executive board and its house of delegates endorse the principles of S. 3780 entitled, "A Program for Prevention and Control of Dental Disease," and urge its adoption by the Congress of the United States; and be it further

Resolved, That copies of this resolution be transmitted to the Kentucky Members of the Congress at the most appropriate and effective time.

J. M. DISMUKES, Jr., *President.*

E. J. BUECHEL, *President-Elect.*

A. B. COXWELL, *Secretary-Treasurer.*

Adopted by executive board of the Kentucky Dental Association, August 21, 1960.

Adopted by house of delegates of the Kentucky Dental Association, August 23, 1960.

A. B. COXWELL, D.M.D.,
Secretary-Treasurer.

[Telegram]

LOUISVILLE, KY., May 23, 1962.

Hon. LISTER HILL,
U.S. Senate, Washington, D.C.:

University of Louisville School of Dentistry is strongly in favor of passage of S. 917 for dental grants-in-aid.

RAYMOND E. MYERS,
Dean, University of Louisville.

[Telegram]

NEW ORLEANS, LA., May 30, 1962.

Senator LISTER HILL,
Chairman, Committee on Labor and Public Welfare,
U.S. Senate, Washington, D.C.:

The Louisiana Dental Association places its full support to the enactment of S. 917, the dental grant-in-aid bill. Availability of earmarked funds for State public dental health program as provided by S. 917 will enable activation of essential new programs planned but inoperative due to lack of funds and judicious expansion of existing dental health programs in our State because of the critical significance of this measure to both the dental and total health of the public. We strongly urge favorable action by your committee and individual member support before the Senate.

THOMAS W. POPE, JR., D.D.S.
President, Louisiana Dental Association.

LOUISIANA STATE BOARD OF HEALTH.
New Orleans, May 31, 1962.

Hon. LISTER HILL,
Chairman, Committee on Labor and Public Welfare,
U.S. Senate, Washington, D.C.

DEAR SENATOR HILL: The Louisiana State Board of Health and the State dental association have respectfully requested each Louisiana Senator and Representative to be on the alert for bills S. 917 and H.R. 4742 and support them when they come before Congress. I mention these requests in order that you may know of Louisiana's interest.

Since bill S. 917 is scheduled for a hearing in your committee, may I state that categorical grants are extremely important to Louisiana. Such grants would permit the Louisiana State Board of Health to—

- (1) Provide necessary dental services to individuals who cannot obtain them for economic or other reasons.
- (2) Expand its educational and preventive programs.
- (3) Develop special study and demonstration programs.
- (4) Establish investigation and research programs.

The funds will also permit the Louisiana State Board of Health to offer more than token services in the following areas:

- (1) Assist with the provision of dental services to the chronically ill and aged.
- (2) Provide consultant services to the State dental association and State agencies.
- (3) Make epidemiological studies to determine the incidence and prevalence ratio of periodontal disease and dental caries among children and adults.
- (4) Promote educational programs for dentists, nurses, school and community groups.
- (5) Implement and develop dental caries control measures.
- (6) Make dental X-ray radiation studies.
- (7) Develop incremental care programs.

May I state further that if the grants are not made available Louisiana cannot strengthen its present inadequate dental services, nor can it develop needed new services. I sincerely hope that your committee will look with favor on this bill and will vigorously support it on the Senate floor.

Sincerely,

PAUL COOK, D.D.S., M.P.H.,
Chief, Dental and School Health Section.

[Telegram]

SKOWHEGAN, MAINE, May 24, 1962.

Senator LISTER HILL,
Chairman, Senate Committee on Labor and Public Health,
Washington, D.C.

DEAR SENATOR: The Maine Dental Association wants to place itself on record as being firmly in favor of S. 917, a bill to provide matching grants for State public health dental programs. We would like to have this statement read into the committee records.

STANLEY M. GOWER, M.D.,
Secretary, Maine Dental Association.

MARYLAND STATE DENTAL ASSOCIATION,
Baltimore, Md., June 7, 1961.

HON. LISTER HILL,
Chairman, Committee on Labor and Public Welfare,
U.S. Senate, Washington, D.C.

DEAR SENATOR HILL: It is my pleasure to report to your committee that the Maryland State Dental Association by official action heartily endorses the Federal legislation as proposed in Senate bill 917 and H.R. 4742 providing for earmarked grants-in-aid for State and local dental health programs.

This endorsement represents the opinion of the dentists of a State in which formal dental education was born and in which for the past 30 years there has existed the closest possible cooperation between the dental profession and the State health department dental health activities in promotion of improved dental health. The proposed grants-in-aid earmarked for dental health will permit an expansion of those activities in the fields of dental health education, preventive dental measures, and corrective dental care that will still better serve the interests of the general public.

Very truly yours,

WILLIAM SCHUNICK, D.D.S., Secretary.

STATE OF MARYLAND,
DEPARTMENT OF HEALTH,
Baltimore, Md., May 19, 1961.

HON. LISTER HILL,
Chairman, Committee on Labor and Public Welfare,
U.S. Senate, Washington, D.C.

DEAR SENATOR HILL: This department, its division of dental health and I, personally, heartily endorse the pending Federal legislation, S. 917 and H.R. 4742, providing earmarked grants-in-aid for State and local preventive and corrective dental health programs. In our endorsement we join the Maryland State Dental Association, the American Dental Association, the American Public Health Association, the State & Territorial Health Officers Association and scores of other national and State professional and scientific groups.

As a long-time private practitioner of medicine, as a one time county health officer and as director of a State health agency I know the extent of need for preventive and remedial dental health measures. It is on the basis of that knowledge that I urge favorable consideration of the proposed legislation.

Sincerely,

PERRY F. PRATHER, M.D., Director.

MASSACHUSETTS DENTAL SOCIETY,
Boston, Mass., May 28, 1962.

HON. LISTER HILL,
*U.S. Senate, Senate Office Building,
 Washington, D.C.*

MY DEAR SENATOR: I am enclosing a copy of a resolution which was adopted on January 29, 1961, at the midwinter session of the house of delegates of our society, representing some 3,200 dentists, and which policy is still in force.

May I respectfully request and urge the passage of this progressive and sound legislation for the benefit of the public health.

Faithfully yours,

HAROLD E. TINGLEY, D.M.D., *Secretary.*

RESOLUTION OF HOUSE OF DELEGATES, JANUARY 29, 1961

Resolution re U.S. Senate bill 3780¹ of the 86th Congress, introduced by Senator Lister Hill, calling for a categorical grant-in-aid dental appropriation at the level of local and State departments of public health

Whereas the dental health problem in this country is one of large and serious proportions and for more than 40 years the grant-in-aid principle has been used to assist State and local governments in developing new programs, expanding and improving existing ones, raising standards of health care and training personnel; and

Whereas the America Dental Association has gone on record in 1956 and reiterated the same in 1960 favoring such a program and requesting constituent society assistance and support in obtaining favorable legislation to this end by adopting favorable resolutions: Be it

Resolved, That the Massachusetts Dental Society requests the adoption of Senate bill 3780¹ by the Congress of the United States calling for dental categorical grants-in-aid at the State and local public health department levels.

HAROLD E. TINGLEY, D.M.D., *Secretary.*

THE COMMONWEALTH OF MASSACHUSETTS,
 DEPARTMENT OF PUBLIC HEALTH,
Boston, May 22, 1962.

HON. BENJAMIN A. SMITH,
Senate Office Building, Washington, D.C.

DEAR SENATOR SMITH: I have only just heard of the possibility that S. 917 will be heard before your Senate Committee on Labor and Public Welfare on May 24, and I hasten to bring the subject matter of this bill to your attention as a matter of no small importance to us.

This bill would provide for assistance to States and/or local communities for the improvement and expansion of their public dental health programs. I am sure I don't have to tell you that we here in Massachusetts suffer seriously from dental disabilities. We here in Massachusetts, at the State level, expend over \$5 per capita in the interest of public health. Less than 2 percent per capita of this figure goes toward the prevention or control of dental diseases or disabilities. It is our feeling that increased support of this branch of public health activity can serve in the long run to improve not only our dental health but our total health as well.

I urge you to support S. 917 as a bill very much in the public interest and one whose merits are agreed upon by the dental profession of Massachusetts.

Will you be good enough to make this letter a part of the public record.

Very truly yours,

ALFRED L. FRECHETTE, *Commissioner.*

¹ Now refers to Senate bill 917.

HARVARD SCHOOL OF DENTAL MEDICINE,
Boston, Mass., May 23, 1962.

HON. BENJAMIN SMITH,
Senate Office Building, Washington, D.C.

DEAR SENATOR SMITH: I would like personally to urge you to support Senate bill 917, currently being considered by the Subcommittee on Health of the Senate Committee on Labor and Public Welfare. Support of public health activities within the field of dental health is sorely needed at every level. This bill, which would establish grants-in-aid to State Departments of Public Health and to dental schools, will provide the backing for a broad attack on problems of dental disease.

Governmental support for research projects at the laboratory and clinical level has been a major factor behind the significant steps recently made in the understanding and treatment of disease. There are, however, many links in the chain of progress from the laboratory to society. To understand and cope with disease at a national level it is necessary to consider many factors which do not enter into the biological mechanisms which produce illness in an individual. Concern with health or disease as it affects communities, States, or nations has traditionally been the domain of public health, and many of the superb accomplishments of medical science have been its victories. The control of tuberculosis and typhoid fever is an excellent example, not of a brilliant scientific discovery, but of successful tactics at the community and national level. The fact that dental caries has not been controlled is not so much a failure in the laboratory as in the community. Were known facts concerning dental disease applied in the fashion that similar facts about typhoid fever are applied, the incidence of dental disease could be expected to decline rapidly.

From a strictly financial point of view Senate bill 917 would seem worthy of your backing. A decrease in dental disease cannot occur until broad support is marshalled behind the public health efforts which are so sorely needed. The public's bill for dental treatment last year was in excess of \$2.2 billion, approaching 1 percent of the net disposable income. Adequate public health measures, using the current knowledge of dental disease, could today reduce the need for the majority of this expense.

Since formal support of Senate bill 917 may possibly be meager, I should appreciate having these remarks made into the minutes of the Subcommittee.

Sincerely yours,

ROY O. GREEP, *Dean.*

[Telegram]

BOSTON, MASS., *May 23, 1962.*

Senator LISTER HILL,
*Chairman, Committee on Labor and Public Welfare,
New Senate Office, Washington, D.C.:*

I strongly urge your favorable consideration S. 917 giving grants-in-aid for dental public health. Even the small projects of this type we currently have at our school are enabling us to begin a major improvement in dental education. More adequate support as made possible by S. 917 would enable us to vastly accelerate a broadening of the outlook of our students toward their obligation in all aspects of all health care for all people.

Dean JOHN W. HEIN.
TUFTS DENTAL SCHOOL.

[Telegram]

LANSING, MICH., *May 22, 1962.*

Senator LISTER HILL,
*Senate Office Building
Washington, D.C.:*

The board of trustees of the Michigan State Dental Association has adopted a resolution in support of S. 917. We believe this bill would fill a critical void in public health programing. If enacted into law we urge the Committee on Labor and Public Health to report favorably and recommend the passage of S. 917.

Sincerely,

J. ROBERT SHORT, D.D.S.,
President, Michigan State Dental Association.

THE UNIVERSITY OF MICHIGAN SCHOOL OF PUBLIC HEALTH,
Ann Arbor, Mich., May 22, 1962.

HON. LISTER HILL,
Chairman, Committee on Labor and Public Welfare,
U.S. Senate, Washington, D.C.

DEAR SENATOR HILL: In my capacity as professor of public health dentistry in this school, I have had occasion over the past years to examine carefully the financing and budgeting of programs of dental public health in several States. Almost without exception all of the programs have been inadequate in salaries and in financing for an operation which even would dent the tremendous amount of dental needs. Furthermore, as a member of the American Public Health Association's Committee on Public Policy and Legislation over the past few years, I have had the opportunity to study many items of public health legislation, including S. 917. After careful consideration and study, I strongly urge favorable consideration of S. 917 during the coming hearings of your committee.

May I respectfully request that this letter be included in the record of the hearings?

Thank you.

Sincerely,

KENNETH A. EASLICK, D.D.S.,
Professor of Public Health Dentistry and
Chairman, Department of Health Development.

THE UNIVERSITY OF MICHIGAN SCHOOL OF PUBLIC HEALTH,
Ann Arbor, Mich., May 22, 1962.

HON. LISTER HILL,
Chairman, Committee on Labor and Public Welfare,
U.S. Senate, Washington, D.C.

DEAR SENATOR HILL: I understand that hearings on S. 917 are to take place shortly. I write urging your favorable consideration of S. 917 on the basis of my experience of 8 years as director of the Division of Dental Health in the New Mexico Department of Public Health, and for the past year as associate professor of public health dentistry at the School of Public Health here at the University of Michigan.

As State dental director in New Mexico for 8 years, I found that the State dental program there constantly was hampered by inadequate funds and consequently by an inadequate staff to tackle the tremendous job of preventing and controlling dental diseases. The State of New Mexico, through its legislature, originally had initiated the State dental program with a modest appropriation, adequate enough to begin the program, but most inadequate to continue the program and to improve it to meet the needs of the people of New Mexico. It would seem that a State such as New Mexico would benefit greatly by the passage of S. 917 which would provide, as you know, categorical grants-in-aid to the States for dental health activities.

In addition, as a teacher of potential public health dentists this past year, I have been impressed by the fact that most of the State dental directors who are attempting to recruit dentists from among the potential graduates of this school are only able to offer salaries which are far below those of private practice. Yet, at the same time, most of the State dental program directors are short of staff to do the tremendous job of attacking the problem of dental diseases—the most common chronic diseases of man.

Therefore, I urge your support of S. 917 and respectfully request that this letter be included as part of the record of your committee's hearings. Thank you.

Sincerely,

DAVID F. STRIFFLER, D.D.S., M.P.H.,
Associate Professor.

MINNESOTA STATE DENTAL ASSOCIATION,
St. Paul, Minn., May 22, 1962.

Hon. LISTER HILL,
U.S. Senate,
Washington, D.C.

DEAR SENATOR HILL: The House of Delegates of the Minnesota State Dental Association in convention, April 2-4, 1962, voted endorsement of S. 917, a bill to provide matching grants for State public dental health programs.

This legislation is very much needed in order to establish and maintain the enlarged dental health programs which the Minnesota State Dental Association believes will serve the public interest.

Your continued support of this legislation will be highly appreciated.

Sincerely yours,

CARL V. E. CASSEL, D.D.S., *Secretary.*

STATE OF MINNESOTA, DEPARTMENT OF HEALTH,
May 22, 1962.

Hon. HUBERT H. HUMPHREY,
U.S. Senator in Congress,
Senate Office Building, Washington, D.C.

MY DEAR MR. HUMPHREY: This letter is to ask your support to the Senate bill 917 which comes up for hearing on Thursday, May 24, 1962. This bill will be an aid to Minnesota in providing the necessary money to expand and develop our dental program in an effort to improve the dental health of the people of Minnesota.

Sincerely yours,

WM. A. JORDAN, D.D.S., M.P.H.,
Chief, Section of Dental Health.

MISSISSIPPI DENTAL ASSOCIATION,
Hattiesburg, Miss., February 6, 1962.

Hon. LISTER HILL,
U.S. Senate, Washington, D.C.

DEAR SENATOR HILL: As president of the Mississippi Dental Association I hope you will see fit to act favorably on H.R. 4742 and S. 917 when a hearing on the bill is held by the Committee on Interstate and Foreign Commerce.

I would like to present some of the basic facts demonstrating the great need of dental grants-in-aid. First the funds are inadequate. Only approximately 2 percent of the Mississippi public health dollar is allocated for dental health, although dental diseases are the most widespread of diseases in civilized man, affecting almost 100 percent of the people. Of Public Health Service funds granted for general health in Mississippi all go to medical programs, none for dental health. Of Children's Bureau funds granted for maternal and child health, only 3 percent is allocated to dental health in Mississippi. We also have an inadequate personnel. Although dental diseases affect nearly all, no local dental health programs exist in Mississippi. One dentist and five hygienists on the State level are attempting to operate on the local level, with the result that dental health services are not adequately available to all areas of the State.

Insufficient personnel and funds do not permit adequate dental health education, consultative services, and research and study projects. No official funds are available to finance minimum dental corrections for the truly needy and deserving child. For medical corrections, such funds are available.

The entire Mississippi Dental Association will appreciate any consideration and help you can render for a program which will benefit the dental health needs of the people of Mississippi.

Sincerely yours,

R. ED. BUSBY, D.D.S., *President.*

THE UNIVERSITY OF MICHIGAN SCHOOL OF PUBLIC HEALTH,
Ann Arbor, Mich., May 22, 1962.

HON. LISTER HILL,
Chairman, Committee on Labor and Public Welfare,
U.S. Senate, Washington, D.C.

DEAR SENATOR HILL: In my capacity as professor of public health dentistry in this school, I have had occasion over the past years to examine carefully the financing and budgeting of programs of dental public health in several States. Almost without exception all of the programs have been inadequate in salaries and in financing for an operation which even would dent the tremendous amount of dental needs. Furthermore, as a member of the American Public Health Association's Committee on Public Policy and Legislation over the past few years, I have had the opportunity to study many items of public health legislation, including S. 917. After careful consideration and study, I strongly urge favorable consideration of S. 917 during the coming hearings of your committee.

May I respectfully request that this letter be included in the record of the hearings?

Thank you.

Sincerely,

KENNETH A. EASLICK, D.D.S.,
Professor of Public Health Dentistry and
Chairman, Department of Health Development.

THE UNIVERSITY OF MICHIGAN SCHOOL OF PUBLIC HEALTH,
Ann Arbor, Mich., May 22, 1962.

HON. LISTER HILL,
Chairman, Committee on Labor and Public Welfare,
U.S. Senate, Washington, D.C.

DEAR SENATOR HILL: I understand that hearings on S. 917 are to take place shortly. I write urging your favorable consideration of S. 917 on the basis of my experience of 8 years as director of the Division of Dental Health in the New Mexico Department of Public Health, and for the past year as associate professor of public health dentistry at the School of Public Health here at the University of Michigan.

As State dental director in New Mexico for 8 years, I found that the State dental program there constantly was hampered by inadequate funds and consequently by an inadequate staff to tackle the tremendous job of preventing and controlling dental diseases. The State of New Mexico, through its legislature, originally had initiated the State dental program with a modest appropriation, adequate enough to begin the program, but most inadequate to continue the program and to improve it to meet the needs of the people of New Mexico. It would seem that a State such as New Mexico would benefit greatly by the passage of S. 917 which would provide, as you know, categorical grants-in-aid to the States for dental health activities.

In addition, as a teacher of potential public health dentists this past year, I have been impressed by the fact that most of the State dental directors who are attempting to recruit dentists from among the potential graduates of this school are only able to offer salaries which are far below those of private practice. Yet, at the same time, most of the State dental program directors are short of staff to do the tremendous job of attacking the problem of dental diseases—the most common chronic diseases of man.

Therefore, I urge your support of S. 917 and respectfully request that this letter be included as part of the record of your committee's hearings. Thank you.

Sincerely,

DAVID F. STRIFFLER, D.D.S., M.P.H.,
Associate Professor.

MINNESOTA STATE DENTAL ASSOCIATION,
St. Paul, Minn., May 22, 1962.

HON. LISTER HILL,
U.S. Senate,
Washington, D.C.

DEAR SENATOR HILL: The House of Delegates of the Minnesota State Dental Association in convention, April 2-4, 1962, voted endorsement of S. 917, a bill to provide matching grants for State public dental health programs.

This legislation is very much needed in order to establish and maintain the enlarged dental health programs which the Minnesota State Dental Association believes will serve the public interest.

Your continued support of this legislation will be highly appreciated.

Sincerely yours,

CARL V. E. CASSEL, D.D.S., *Secretary.*

STATE OF MINNESOTA, DEPARTMENT OF HEALTH,
May 22, 1962.

HON. HUBERT H. HUMPHREY,
U.S. Senator in Congress,
Senate Office Building, Washington, D.C.

MY DEAR MR. HUMPHREY: This letter is to ask your support to the Senate bill 917 which comes up for hearing on Thursday, May 24, 1962. This bill will be an aid to Minnesota in providing the necessary money to expand and develop our dental program in an effort to improve the dental health of the people of Minnesota.

Sincerely yours,

WM. A. JORDAN, D.D.S., M.P.H.,
Chief, Section of Dental Health.

MISSISSIPPI DENTAL ASSOCIATION,
Hattiesburg, Miss., February 6, 1962.

HON. LISTER HILL,
U.S. Senate, Washington, D.C.

DEAR SENATOR HILL: As president of the Mississippi Dental Association I hope you will see fit to act favorably on H.R. 4742 and S. 917 when a hearing on the bill is held by the Committee on Interstate and Foreign Commerce.

I would like to present some of the basic facts demonstrating the great need of dental grants-in-aid. First the funds are inadequate. Only approximately 2 percent of the Mississippi public health dollar is allocated for dental health, although dental diseases are the most widespread of diseases in civilized man, affecting almost 100 percent of the people. Of Public Health Service funds granted for general health in Mississippi all go to medical programs, none for dental health. Of Children's Bureau funds granted for maternal and child health, only 3 percent is allocated to dental health in Mississippi. We also have an inadequate personnel. Although dental diseases affect nearly all, no local dental health programs exist in Mississippi. One dentist and five hygienists on the State level are attempting to operate on the local level, with the result that dental health services are not adequately available to all areas of the State.

Insufficient personnel and funds do not permit adequate dental health education, consultative services, and research and study projects. No official funds are available to finance minimum dental corrections for the truly needy and deserving child. For medical corrections, such funds are available.

The entire Mississippi Dental Association will appreciate any consideration and help you can render for a program which will benefit the dental health needs of the people of Mississippi.

Sincerely yours,

R. ED. BUSBY, D.D.S., *President.*

MISSISSIPPI STATE BOARD OF HEALTH,
Jackson, Miss., May 21, 1962.

Senator LISTER HILL,
U.S. Senate,
Washington, D.C.

DEAR SENATOR HILL: Favorable action on S. 917 is a must if the dental health program in Mississippi is to begin to meet adequately the dental needs of our population.

My letter of December 27, 1961, states the deficiency in funds, and therefore personnel and programs in Mississippi dental health activities. The stimulus of a grants-in-aid program in initiating and expanding efforts of the State and localities cannot be overemphasized.

Dental public health programs generally have suffered too long from a lack of funds and a program to stimulate State and local resources. Passage of a Federal categorical grants-in-aid program in this important health field is urgently needed now.

Your consideration of the dental needs of the people is appreciated and to be commented.

Sincerely,

AARON TRUBMAN, D.D.S., M.P.H.,
Supervisor, Public Health Dentistry.

HANNIBAL, Mo., May 31, 1962.

HON. STUART SYMINGTON,
U.S. Senate,
Washington, D.C.

MY DEAR SENATOR: May I have your support on Senate bill No. 917 and would you kindly urge hearings on this legislation by Senate Council on Labor and Public Welfare.

The Nation's dental health status is one of universal disease prevalence with vast amounts of treatment needs causing untold misery and suffering. The success of other grant-aided programs indicates that this legislation is essential if dental health programs are to be successful.

I urge your support and thank you for your interest in this matter.

Very truly yours,

LEDRU M. WOOD, D.D.S.,
President-Elect, Missouri Dental Association.

MISSOURI DENTAL ASSOCIATION,
Jefferson City, Mo., May 22, 1962.

HON. LISTER HILL,
U.S. Senate,
Washington, D.C.

DEAR SENATOR HILL: The Missouri Dental Association adopted the following resolution, November 1960, with regard to providing matching grants for State dental health programs.

Resolved, That the Missouri Dental Association favors categorical grant-in-aid for State dental health activities.

Sincerely,

E. D. SUGGETT, D.D.S.,
Secretary-Treasurer.

DEPARTMENT OF PUBLIC HEALTH AND WELFARE,
THE DIVISION OF HEALTH OF MISSOURI,
Jefferson City, Mo., May 21, 1962.

HON. LISTER HILL,
U.S. Senate,
Senate Office Building, Washington, D.C.

MY DEAR SENATOR HILL: Some time ago I wrote you regarding support for Senate bill 917 which you introduced. At this time I wish to again reiterate my

complete support. Those of us in the promotion of dental public health activities are sorely in need of this legislation, not only to augment existing funds, but to stimulate additional funds from State legislatures.

The several special groups requiring new or additional programs such as the chronically ill and aging, the handicapped, and the thousands of normal children unable to experience and receive dental treatment shows up the need for this support.

I hereby request this letter be inserted into the minutes of the hearing so that others interested may know my feelings and our need.

Sincerely,

JAMES R. ROBINSON,
Consultant in Dental Health.

U.S. SENATE,
May 10, 1961.

HON. LISTER HILL,
*Chairman, Senate Committee on Labor and Public Welfare,
U.S. Senate, Washington, D.C.*

DEAR MR. CHAIRMAN: Enclosed is a letter I have received from the executive officer of the State Board of Health of the State of Montana, in which he expresses an interest in S. 917, the bill designed to improve State dental health programs.

You will note that the State of Montana is very interested in this legislation and I would, therefore, request that Dr. G. D. Carlyle Thompson's communication be made a part of the record on S. 917 when it is considered by the Senate Committee on Labor and Public Welfare.

Thanking you and with best personal wishes, I am,

Sincerely yours,

MIKE MANSFIELD.

STATE OF MONTANA,
STATE BOARD OF HEALTH,
Helena, Mont., May 5, 1961.

HON. MIKE MANSFIELD,
*U.S. Senator,
Senate Office Building, Washington, D.C.*

DEAR SENATOR MANSFIELD: Two bills introduced into this Congress concerning dental health are of interest to us in Montana. These are S. 917 and H.R. 4742, and provide for improving State dental health programs.

While dental disease is not recognized in the mortality studies in the same way that other disease entities are, it is, nevertheless, one of our major health problems. This is true not only in the country as a whole but also specifically in Montana as evidenced by the very high percentage of school children with dental caries.

In accordance with Montana law, the State board of health has a division of dental health which has been supported since 1943 through State appropriations and with some assistance from maternal and child health grants. Our dental health program continues to be on a limited basis with the present budget approximately \$25,000 a year.

Passage of either of these bills would enable us in Montana to substantially improve the dental health program in this State.

S. 917 is now in the Subcommittee on Health of the Senate Committee on Labor and Public Welfare. Senator Lister Hill of Alabama is chairman of this subcommittee.

I hope this information will be of value to you. If any additional information is desired with regard to these bills, I would be happy to try and obtain it for you.

Thank you very much for your interest.

Sincerely yours,

G. D. CARLYLE THOMPSON, M.D.,
Executive Officer.

U.S. SENATE, May 9, 1961.

Hon. LISTER HILL,
New Senate Office Building,
Washington, D.C.

DEAR SENATOR HILL: The enclosed letter from the executive officer of Montana's Board of Health endorses your S. 917 for improving State dental health programs.

I wish to add my endorsement and ask that Dr. Thompson's and my letter be made part of the record when hearings are held.

Sincerely,

LEE METCALF.

STATE OF MONTANA,
 STATE BOARD OF HEALTH,
Helena, Mont., May 5, 1961.

Hon. LEE METCALF,
U.S. Senator, Senate Office Building,
Washington, D.C.

DEAR SENATOR METCALF: Two bills introduced into this Congress concerning dental health are of interest to us in Montana. These are S. 917 and H.R. 4742, and provide for improving State dental health programs.

While dental disease is not recognized in the mortality studies in the same way that other disease entities are, it is, nevertheless, one of our major health problems. This is true not only in the country as a whole but also specifically in Montana as evidenced by the very high percentage of schoolchildren with dental caries.

In accordance with Montana law, the State board of health has a division of dental health which has been supported since 1943 through State appropriations and with some assistance from maternal and child health grants. Our dental health program continues to be on a limited basis with the present budget approximately \$25,000 a year.

Passage of either of these bills would enable us in Montana to substantially improve the dental health program in this State.

S. 917 is now in the Subcommittee on Health of the Senate Committee on Labor and Public Welfare. Senator Lister Hill of Alabama is chairman of this subcommittee.

I hope this information will be of value to you. If any additional information is desired with regard to these bills, I would be happy to try and obtain it for you.

Thank you very much for your interest.

Sincerely yours,

G. D. CARLYLE THOMPSON, M.D.,
Executive Officer.

[Telegram]

HELENA, MONT., May 22, 1962.

Hon. LEE METCALF,
Senate Chamber, Washington, D.C.:

Dental health problems in Montana and the Nation are of large and serious proportions. Available funds radically limit State dental health programs. We urge serious consideration of Senator Hill's bill S. 917 at hearing of Subcommittee on Health of Senate Committee on Labor and Welfare, May 24.

JOHN S. ANDERSON,
Executive Officer, Montana State Board of Health.

[Telegram]

LINCOLN, NEBR., May 25, 1962.

Hon. LISTER HILL,
U.S. Senator, Senate Building, Washington, D.C.

The Nebraska Dental Association, through action by its House of Delegates, is on record favoring and supporting S. 917 which earmarks categorical Federal grants-in-aid for public dental health programs to strengthen dental health services at State and community levels and for special studies pertaining to Dental health problems specifically for the prevention and control of dental diseases.

F. A. PIERSON, D.D.S., *Secretary.*

NEVADA STATE DENTAL SOCIETY,
Reno, Nev., May 18, 1962.

Senator LISTER HILL,
Chairman, Committee on Labor and Public Welfare,
U.S. Senate Office Building, Washington, D.C.

DEAR SENATOR HILL: The Nevada State Dental Society at its last annual meeting passed a resolution favoring S. 917 and H.R. 4742 which would establish categorical Federal grant-in-aid funds to States for development and maintenance of dental health programs.

The officers and members of the Nevada State Dental Society through their executive council wish at this time to reaffirm this resolution and request that it be included in the record.

Sincerely yours,

DAVID W. MELARKEY, D.D.S.,
President.

OMAR M. SEIFERT, D.D.S.,
Secretary.

NEVADA STATE DEPARTMENT OF HEALTH,
Reno, Nev., May 18, 1962.

Senator LISTER HILL,
Chairman, Committee on Labor and Public Welfare,
U.S. Senate Office Building, Washington, D.C.

DEAR SENATOR HILL: On January 9, 1962 at a regular meeting, the Nevada State Board of Health went on record as approving the proposed dental grant-in-aid bills (S. 917 and H.R. 4742).

The board approved the use, by the dental division of the State health department, of any Federal grant-in-aid funds made available through this legislation.

Sincerely yours,

DANIEL J. HURLEY, M.D.,
State Health Officer.

NEW HAMPSHIRE DENTAL SOCIETY,
Manchester, N.H., May 23, 1962.

Senator LISTER HILL,
Senate Office Building,
Washington, D.C.

DEAR SENATOR HILL: We, as dentists, are well aware of the high incidence of dental decay in New Hampshire as well as in other New England States and realize the lack of public funds for dental health programs in our State.

In view of the above, the executive committee of the New Hampshire Dental Society has voted unanimously that the Senate Committee on Labor and Public Welfare look with favor upon S. 917, a bill to provide grants-in-aid for dental health programs in the States.

It is requested that the above be entered in the Congressional Record.

Yours truly,

Dr. FLOYD E. WILLIAMS, *Secretary.*

THE STATE OF NEW HAMPSHIRE DEPARTMENT OF HEALTH,
Concord, May 23, 1962.

Re S. 917 earmarked grant-in-aid dental health programs.

Senator LISTER HILL,
Chairman, Committee on Labor and Welfare,
U.S. Senate, Senate Office Building,
Washington, D.C.

DEAR SENATOR HILL: S. 917 will provide the necessary freedom for dental public health personnel and dentists in private practice, to initiate long-needed programs, and expand existing activities to protect the dental health of citizens of all ages.

Among other programs, long planned for the State of New Hampshire, that could be started are: (1) Training courses for dentists, in public and private practice, in the very special techniques required to provide dental care for cerebral palsy patients, those afflicted with convulsive disorders, and the mentally retarded. (2) Adequate dental care for mental hospital patients, custodial institutions, and industrial schools. (3) Special equipment could be made available for dental practitioners to care for the homebound, patients in nursing homes and county farms, the chronically ill, and the aged.

Present preventive programs of service and dental health education would be expanded. Courses given in teacher colleges, other colleges, and the university would be held at more frequent intervals.

The New Hampshire Legislature has indicated a sustained interest in dental public health. The exact ratio of State funds to support dental programs in relation to present Federal funds now made available is 7.90 to 1. If local moneys are included the ratio would reach, at least, 15 to 1.

For more than 20 years all present professional members of this bureau have been keenly aware of the need for earmarked funds for dental programs. S. 917 would free the bureau from budgetary imposed restrictions. The potentialities of great improvement in dental health could be realized.

Please have this letter inserted in the Congressional Record.

Respectfully submitted.

FRANCIS I. LIVINGSTON, D.D.S., L.D.S.(M), M.S.P.H., F.A.C.D.,
Director, Bureau of Dental Public Health.

NEW HAMPSHIRE DENTAL SOCIETY,
Laconia, N.H., May 24, 1962.

Senator LISTER HILL,
Chairman, Committee on Labor and Welfare,
U.S. Senate.

DEAR SENATOR HILL: I would like to go on record as supporting bill S. 917, Grants -in-aid to dental health earmarking grant-in-aid funds for dental activity.

May I request that a copy of this letter go to the Congressional Record?

Very truly yours,

GORDON G. MACALASTER, D.M.D.

MANCHESTER, N.H., May 24, 1962.

Senator LISTER HILL,
U.S. Senate,
Washington, D.C.

DEAR SENATOR: I am writing to you in your capacity as chairman of the Committee on Labor and Welfare.

I respectfully ask your support for Senate bill 917, grants-in-aid for dental health.

New Hampshire has one of the largest caries rate in the Nation, and we do-early need unencumbered funds for public education in the realm of dental disease.

Very sincerely yours,

ROBERT M. MILLER, D.M.D.

[Telegram]

MANCHESTER, N.H., May 22, 1962.

Senator LISTER HILL,
Chairman, Committee on Labor and Public Welfare,
Senate Office Building,
Washington, D.C.

DEAR SENATOR HILL: I respectfully urge you to help promote the passage of Senate bill 917 which will grant funds for dental research.

Dental disease is the oldest prevalent problem of man and the most neglected.

The public image of the role of the dentist is limited too much to the mechanical and preventive aspects. There is much to be learned about the diseases of the mouth and dental research can produce results as dramatic as polio vaccine and cancer control.

I am a graduate of the Medical College of Virginia, class of 1935, past president of the New Hampshire Dental Society and a fellow of the American College of Dentists.

I should like to request that this letter be read into the records of the committee hearing on bill 917.

Respectfully submitted.

ELWOOD F. MACRURY, D.D.S., F.A.C.D.

MANCHESTER, N.H., May 22, 1962.

Senator LISTER HILL,
Chairman, Senate Labor and Public Welfare Committee,
Senate Office Building, Washington, D.C.

DEAR SENATOR HILL: I understand that your committee will this week consider its recommendation on Senate bill 917, relating to the appropriation of Federal funds for the furtherance of dental research. As a practicing dentist, part-time dental teacher, and occasional dental researcher, I believe that the encouragement of dental research is one means of simultaneously increasing the sum of knowledge of dental problems, improving the standard of dental teaching, and thereby improving the standard of dental care.

We have come to judge the relative quality of the dental schools of this country by the caliber of research work produced within their confines. You know yourself that in your own State of Alabama the entire program of the medical and dental schools at the University Center in Birmingham has been predicated under Dr. Joseph Volker's leadership upon an active research program which draws all the students into its various phases. The success of the program has been evident in the recognition awarded graduates of the school.

From my own experience as a past chairman of the New Hampshire Council on Dental Health and as a faculty member of the Stomatology Department at Boston University School of Medicine, I believe that the Federal Government is in the best position to encourage basic research in dentistry, divorced from commercial conditions and considerations as much as possible. To that end, I hope your committee will favorably recommend the pending legislation.

I would appreciate your reading my letter into the record of your committee's deliberations if it is possible. Thank you for your consideration.

Sincerely yours,

DAVID G. STAHL, D.M.D.

MAY 24, 1962.

Senator LISTER HILL,
Chairman, Committee on Labor and Public Welfare,
Senate Office Building, Washington, D.C.

DEAR SENATOR HILL: This letter is to express our unqualified endorsement of the bill (S. 917) for grant-in-aid funds to States for the promotion and expansion of programs of dental health.

The Legislature of the State of New Hampshire supports the activities of the bureau of dental public health, State department of health. The ratio of State funds to Federal funds made available is about 8 to 1.

The passage of S. 917 would permit programs of dental public health, for the public good, to be expanded, and many new programs to be initiated. These

new programs have been in the planning stage with the New Hampshire Dental Society cooperation for several years. Lack of financial support has prevented their initiation.

Please have this letter inserted in the Congressional Record.

Very truly yours,

WENDELL E. FITTS, D.M.D.,
Director, Executive Council, New Hampshire Dental Society.

STATE OF NEW JERSEY, DEPARTMENT OF HEALTH,
Trenton, N.J., May 18, 1962.

HON. HARRISON A. WILLIAMS, JR.,
*U.S. Senate,
Washington, D.C.*

DEAR SENATOR WILLIAMS: I have been informed that bill, S. 917, which was introduced by Lister Hill on February 13, 1961, has now been called up for hearings.

As you will recall I wrote to you on March 28, 1961, emphasizing the importance of such legislation to the dental health program in New Jersey. The passage of this bill will enable us to expand our programs in the fields of dental care for children with physical handicaps, dental care for the children of migrant laborers, and will help us to solve the problem of providing dental supported services for the aged population. S. 917 will enable us to carry out other aspects of the dental public health program which will provide more adequate dental health for the people of New Jersey.

I hope that you will give S. 917 your support.

Sincerely,

DAVID R. WALLACE, D.D.S., M.P.H.,
Coordinator, Dental Health Program.

STATE OF NEW JERSEY, DEPARTMENT OF HEALTH,
Trenton, N.J., May 18, 1962.

HON. CLIFFORD P. CASE,
*U.S. Senate,
Washington, D.C.*

DEAR SENATOR CASE: I have been informed that bill, S. 917, which was introduced by Lister Hill on February 13, 1961, has now been called up for hearings.

As you will recall I wrote to you on March 28, 1961, emphasizing the importance of such legislation to the dental health program in New Jersey. The passage of this bill will enable us to expand our programs in the fields of dental care for children with physical handicaps, dental care for the children of migrant laborers, and will help us to solve the problem of providing dental supported services for the aged population. S. 917 will enable us to carry out other aspects of the dental public health program which will provide more adequate dental health for the people of New Jersey.

I hope that you will give S. 917 your support.

Sincerely,

DAVID R. WALLACE, D.D.S., M.P.H.,
Coordinator, Dental Health Program.

[Telegram]

SANTA FE, N. MEX., May 23, 1962.

HON. LISTER HILL,
*Chairman, Committee on Labor and Public Welfare,
U.S. Senate, Washington, D.C.:*

New Mexico Department of Public Health requests favorable consideration of S. 917. Dental health grants have improved dental public health in New Mexico and are helping to provide dental care to persons in areas without dentists. These grants are appropriate and are of great help.

STANLEY J. LELAND, M.D.,
New Mexico Department of Public Health.

NEW MEXICO DENTAL ASSOCIATION,
Las Vegas, May 31, 1962.

Senator LISTER HILL,
Senate Office Building,
Washington, D.C.

DEAR SENATOR HILL: Enclosed is a copy of a resolution approved by the board of directors of the New Mexico Dental Association on August 3, 1960. This resolution was subsequently endorsed by the full executive council of our State association.

This resolution was referred to you in August 1960. There have been no changes with respect to the ability of the State of New Mexico to handle the public health dental programs; therefore, the New Mexico Dental Association again urges your committee to report favorably on S. 917, the bill to provide matching grants for State public dental health programs.

Sincerely yours,

EUGENE P. PURTELL, D.D.S., *Secretary.*

RESOLUTION

Whereas a great need exists in the State of New Mexico for improved health facilities, including dental health facilities; and

Whereas the New Mexico Dental Association, in cooperation with the dental division of the department of public health, has made numerous proposals to the New Mexico Legislature; and

Whereas many of these proposals have not been acceptable primarily because of the shortage of funds; and

Whereas the New Mexico Dental Association and the dental division of the department of public health are continuing plans for improved dental health programs in the State of New Mexico: Therefore be it

Resolved, That the New Mexico Dental Association go on record as favoring Federal grants-in-aid for the dental public health to the States.

BOARD OF DIRECTORS, NEW MEXICO
DENTAL ASSOCIATION,
EUGENE P. PURTELL, D.D.S.,
Secretary.

NEW MEXICO DEPARTMENT OF PUBLIC HEALTH,
Santa Fe, May 18, 1962.

HON. LISTER HILL,
Chairman, Committee on Labor and Public Welfare,
U.S. Senate, Washington, D.C.

DEAR SENATOR HILL: I understand that hearings will be conducted Thursday, May 24, on Senate bill 917 concerning dental grants-in-aid for the States.

I know that with your past and continuing interest in dental problems throughout the United States I do not need to remind you of the importance of this bill. However, I would like to point out one problem in the State of New Mexico that illustrates the need for these funds. The division of dental health of the New Mexico Department of Public Health operates, with the sanction of the New Mexico Dental Association, a mobile dental unit, in attempting to meet the dental needs of indigent children in remote areas in which dental care is not available. At the present time this unit is serving 20 communities which is the capacity load for one unit. For several years we have had on file requests from more than 40 additional communities that are in dire need of this same type of service. Because State and local funds have not been available, this has been impossible to remedy entirely. We have with a great deal of difficulty managed to get together enough money to start another unit in operation in September but because of shortage of funds the operation of the second unit will be limited. Certainly, this is one way that grant-in-aid funds could be used to a very great advantage for the good of the children in the State of New Mexico.

In view of the fact that dental diseases have reached epidemic proportions throughout the United States, there is no question as to the need for this legislation.

I would appreciate it if you would incorporate this letter into the record of the official hearings.

Sincerely yours,

WALTER D. ATKINS, D.D.S.,
Director, Division of Dental Health.

NEW YORK, N.Y., May 29, 1962.

Senator LISTER HILL,
Senate Building, Washington, D.C.:

The Dental Society of the State of New York supports and strongly urges the passage of Senate bill 917 which provides for grants-in-aid for State dental public health program.

PERCY T. PHILLIPS, *Executive Secretary.*

ALBANY, N.Y., May 31, 1962.

Hon. LISTER HILL,
*Chairman, Senate Committee on Labor and Public Welfare,
Washington, D.C.:*

I respectfully recommend Senate approval of S. 917. Dental defects which constitute one of the most prevalent diseases to which man is subject are largely preventable and readily correctible.

New York State administers a large-scale dental public health program, including research, caries prevention, and correction and rehabilitation of physically handicapping defects.

Much still needs to be done in the above field and in new fields such as dental problems for the chronically ill and aged. A grants-in-aid program will do much to expand ongoing programs and initiate needed new ones. Please include this telegram in the hearings on S. 917.

DAVID AST, D.D.S.,
*Director, Bureau of Dental Health,
New York State Department of Health.*

THE COMMISSIONER OF HEALTH,
CITY OF NEW YORK,
New York, N.Y., May 24, 1962.

Senator JACOB K. JAVITS,
Senate Office Building, Washington, D.C.

DEAR SENATOR JAVITS: I have just learned that the Senate Committee on Labor and Public Welfare, of which you are a member, is currently giving consideration to the dental grant-in-aid bill, S. 917. It is the purpose of this letter to express my strong endorsement for this legislation and to solicit your support.

Even in New York City, with all its resources, the dental problem is overwhelming. We are here dealing with universal afflictions and accumulated neglect. It has been our observation that the undramatic nature of dental diseases and the costs of treatment are primary factors in producing this picture of gross neglect.

As you are well aware, public health people are currently very much concerned and involved with the general problem of medical care. It seems to me that almost every aspect of this problem which comes to our attention has an important dental component. New York State's medical-aid-to-the-aged program has just been amended to provide for dentures to eligible oldsters. We are just beginning to apply the prepayment or insurance principle to dental care. Dental service in nursing homes is now demanding our attention as well as the provision of dental service to the homebound. And in our development of various types of outpatient, ambulatory clinic facilities the demands and the need for dental components is universal.

The foregoing are cited as samples of the kinds of activities in the dental field which call for experimentation and demonstration. Involved here is everything from the development of portable dental equipment to the training of dentists in their use, from comprehensive studies of the dental problem in various segments of the population to reorganization of community agencies and resources to better meet that problem.

Senate bill 917 would make it possible for substantial progress to be made in the important and largely neglected area of dental health. It is with this background that I am prompted to express my support and recommend your favorable action on this bill.

May I request that this communication be included as reference in the committee proceedings. Be assured that I would welcome any request you might have for additional specific comment, information, or elaboration.

Sincerely yours,

LEONA BAUMGARTNER, M.D.,
Commissioner of Health.

NORTH CAROLINA STATE BOARD OF HEALTH,
Raleigh, April 28, 1961.

HON. LISTER HILL,
U.S. Senate, Washington, D.C.

DEAR SENATOR HILL: North Carolina public health dentists are vitally interested in bills, S. 917, which you introduced, and H.R. 4742, introduced by Representative Oren Harris. This proposed legislation is to provide a grant-in-aid program for the prevention and control of dental diseases.

North Carolina was the first State to include dentistry in its State public health program. A dental public health program for the children in the elementary schools of North Carolina was initiated in 1918. This program has grown and developed into one which has won and held acknowledged leadership in the field of dental public health.

Dental public health programs in North Carolina are based on the premises that: First, public health is chiefly concerned with prevention; second, dental diseases are preventable; third, prevention may best be accomplished through education to provide a framework of knowledge which will establish good dental health attitudes and practices; and, fourth, education must begin with the child. The basic program in North Carolina provides, insofar as funds and staff will permit, the following services: dental health instruction and dental inspections for all children; dental corrections for underprivileged children under 13 years of age; referrals to private practitioners for the other children; and consultative services for lay and professional individuals and groups.

Local and State appropriations have been used as wisely as we know how in order to serve the greatest number of people in our State. However, we are able to provide the above dental health services for only 20 percent of our 6- to 13-year-old children. There exists an urgent need to extend these services to the rest of our school population. Programs need to be instituted for the pre-school children, for the aged, for the chronically ill, and for the handicapped. Programs need to be expanded in the areas of education, prevention, diagnosis, treatment, research, and evaluation.

It is true that dental diseases are not generally thought of as being catastrophic. However, the role of dental health in general health is being considered more and more in health circles, and oral diseases are recognized as being contributory factors in the major death-causing diseases. Dental disease is almost universal in its attack upon our population. As one of the main reasons for industrial absenteeism, it assumes economic significance.

Federal grants-in-aid have resulted in great progress in the fights against cancer, tuberculosis, heart disease, mental health, crippling diseases of children, and venereal disease. Dental disease needs this same type of help. Without such assistance we can barely hold the line, much less expand present programs or meet the urgent needs in other areas.

We greatly appreciate your support of this legislation.

Yours very truly,

E. A. PEARSON, Jr., D.D.S.,
Director Division of Oral Hygiene.

Approved:

J. W. R. NORTON, M.D., *State Health Director.*

[Telegram]

RALEIGH, N.C., May 24, 1962.

HON. LISTER HILL,
Chairman, Committee on Labor and Public Welfare,
U.S. Senate, Washington, D.C.:

Happy to learn bill S. 917 is before your committee today. Reaffirm support of public health dentists of North Carolina as stated in my letter of April 28, 1961.

E. A. PEARSON, Jr.,
Director, Division of Oral Hygiene,
North Carolina State Board of Health.

NORTH CAROLINA DENTAL SOCIETY,
 June 28, 1961.

HON. LISTER HILL,
U.S. Senate,
Washington, D.C.

MY DEAR SENATOR HILL: The house of delegates of the North Carolina Dental Society at its 105th annual session May 14-17, 1961, unanimously endorsed enactment of Senate bill 917 and House bill 4742 to provide Federal categorical grants-in-aid to support dental public health programs at State and local levels.

In 1918 the North Carolina State Board of Health, with the cooperation of the North Carolina Dental Society, established a statewide public dental health program to meet the dental needs of 6- to 13-year-old children. Our society has given its full support to this program through the years. We are aware of the need to extend these services to the remainder of our school population and to preschool children as well as services to the aged, the chronically ill, and the handicapped.

The above-mentioned bills would provide this needed assistance and enable North Carolina to more adequately meet the dental needs in this State.

We earnestly solicit your support of S. 917.

Sincerely yours,

S. BYRON TOWLER, D.D.S.,
Secretary-Treasurer.

[Telegram]

RALEIGH, N.C., May 24, 1962.

Senator LISTER HILL,
Chairman, Senate Committee on Labor and Public Welfare,
U.S. Senate, Washington, D.C.:

The North Carolina Dental Society endorses S. 917 to provide matching grants for State public dental health programs and urges that it be favorably reported out of committee.

E. D. BAKER, D.D.S.,
President, North Carolina Dental Society.

STATE DEPARTMENT OF HEALTH,
 Bismarck, N. Dak., May 21, 1962.

HON. QUENTIN BURDICK,
U.S. Senate
Washington, D.C.

DEAR SENATOR BURDICK: S. 917, which would provide a grant-in-aid program for State dental programs, appears slated for Senate consideration in the near future. Passage of this bill would be of great aid to the North Dakota Department of Health and its dental program.

I wrote you concerning S. 917 when it was first introduced in 1961 and was happy to receive your letter in return indicating your support. I would like to again list the reasons why this grant-in-aid program is needed in North Dakota.

Dental caries has increased in North Dakota, as in other States over the years in direct proportion to the standard of living. Children in Barnes and Walsh Counties were found to have 50 percent more dental caries in 1953 than in 1933.

Fifteen-year-old high school sophomores in Minot and Grand Forks were recently found to average over 10 permanent teeth attacked by caries. In 1940, widespread surveys found an average of seven.

Fortunately, all our larger North Dakota communities are now fluoridating their water. This will be considerable help to future generations in these communities, but of course will not help those people growing up on farms and in small towns where water fluoride is not present in sufficient quantity.

Dental caries is preventable through the conscientious use of good oral hygiene and eating habits. The disease of the investing structures of the teeth, periodontoclasia or pyorrhea, is also largely preventable.

Dental science has known how to control these diseases for years. The fact that the incidence of dental caries has continued to rise and that a great many of our people regard tooth loss through caries and pyorrhea as inevitable is proof that we have not effectively educated the public in dental health matters.

The Dental Division of the North Dakota State Department of Health has two professional employees, one dentist and one dental hygienist. The State legislature has appropriated \$25,000 a biennium for the division at the last three sessions. To this, Federal maternal and child health funds have been added to give us a yearly budget of about \$25,000.

The program of the dental division is mainly educational. With a staff of two and limited funds, our services have been spread very thinly over the State. For example, with more adequate funds additional hygienists could be employed to carry on thorough educational programs in the schools. Dental health lectures and materials could be supplied at a greatly increased rate to the State's colleges. Dental care could be facilitated or supplied to special groups in need, such as aged, institutionalized, and crippled. In short, with increased funds and personnel we could develop a dental health program that would have an impact on the public as a whole in contrast to our present program of little more than token effect on the dental health of North Dakotans.

Your support of this legislation would be greatly appreciated by everyone interested in dental health.

Sincerely,

JOHN K. PETERSON, D.D.S.,
Director, Division of Dental Health.

STATE OF OHIO, DEPARTMENT OF HEALTH,
Columbus, Ohio, May 22, 1962.

Hon. LISTER HILL,
U.S. Senate
Washington, D.C.

DEAR SENATOR HILL: I am writing with regard to S. 917 (to provide a grant program for the prevention and control of dental diseases) which, I understand, is to be considered by the Senate in the near future.

For many years the dental public health programs in Ohio have not progressed to a desirable level—primarily so because of a lack of categorical funds, both on a State and local level. In Ohio the ratio of practicing dentists to population has decreased in the last 14 years from 1 dentist to 1,700 population to 1 dentist to 2,132 population. It can be expected that this trend will continue and that the incurred deficit of dental care must be picked up through a progressive dental public health program. To promote and implement a strong program, the State and local health departments need assistance.

The earmarking of Federal funds has been a highly successful method in the implementation of special programs in such areas as tuberculosis, cancer, heart disease, crippled children's services, and purchase of poliomyelitis vaccine. It is our feeling that dental health belongs in this special category.

Categorical funds have in the past also resulted in increases in expenditures of local funds. It is anticipated that local increases would also occur relative to dental funds.

Prevention is the keystone of public health activity, and will with certainty be a major objective for which dental funds will be expanded if they are made available. Future expenditures for repair and rehabilitation, which the State and Federal Government are often obligated to assume, can therefore be expected to decrease.

Initiation of new and expanding dental programs within the total public health picture will require funds for training of personnel, demonstration projects, studies and surveys. These are presently not being adequately provided for in the Ohio Department of Health budget. Less than 1 percent of our total department funds is made available for preventive dental programing, yet on a national basis, the public is spending 17 percent of its health dollar for dental repair.

I strongly endorse the passage of S. 917 and trust the Senate will consider it favorably. I would greatly appreciate this endorsement being made a part of the record.

Sincerely yours,

RALPH E. DWORK, M.D., *Director of Health.*

STATE OF OHIO DEPARTMENT OF HEALTH,
May 26, 1962.

HON. LISTER HILL,
U.S. Senate, Washington, D.C.

DEAR SENATOR HILL: I am writing with regard to S. 917 which would provide categorical grant-in-aid funds on a matching basis to State dental public health programs. It is my understanding the bill either is, or will soon be, in hearing by the Senate.

For the past 6 years, the dental public health program in Ohio has operated on a subminimal budget and, as chief of the division of dental hygiene during this period, I have been continually faced with the inability to initiate and sustain many of the needed preventive programs. In reviewing the record of the Ohio Department of Health for the past 20 years, I find a quantity of health programs demonstrated and maintained (heart, cancer, TB, water, sewage, polio, etc.), yet dental has never been a major program and has always failed in its request for adequate staff and needed funds. I can foresee no change locally in the future budget and this can be credited to the not dramatic aspect of dental diseases. Less than 1 percent of the department's health budget annually goes into the support of divisional activities, yet dental diseases and disorders are chronic conditions affecting almost 100 percent of the people.

An educated estimate of the purchase of dental care by the people of Ohio in 1961 would be over \$100 million and our surveys have continually indicated less than half of the people are receiving adequate dental care. We have two dental schools in Ohio, yet our ratio of dentist to population is decreasing each year.

The frustrating aspect of this is that we do have preventive measures that can be successfully initiated and maintained but they require adequate staffing and available funds. It is my opinion categorical funds will be of major importance in assisting the State dental programs in the preventive approach.

As a member of the State and Territorial Dental Directors Association, I strongly endorse the passage of S. 917 and would appreciate this endorsement being made a part of the Senate record.

Sincerely yours,

E. E. O'BRIAN, D.D.S., M.P.H.,
Chief, Division of Dental Hygiene.

OKLAHOMA STATE DENTAL ASSOCIATION,
Oklahoma City, Okla., May 25, 1962.

Senator ROBERT S. KERR,
U.S. Senate,
Senate Office Building,
Washington, D.C.

DEAR SENATOR KERR: Senator Lister Hill, Democrat from Alabama, chairman, Senate Committee on Labor and Public Welfare, is currently holding hearings on Senate bill 917.

We would greatly appreciate your influence in getting this bill favorably reported to the Senate.

Thank you very much.

Sincerely,

DONALD E. OXFORD, D.D.S.,
Chairman, Council on Legislation.

OKLAHOMA STATE DENTAL ASSOCIATION,
Oklahoma City, Okla., May 25, 1962.

Senator A. S. MIKE MONRONEY,
U.S. Senate,
Senate Office Building,
Washington, D.C.

DEAR SENATOR MONRONEY: Senator Lister Hill, Democrat from Alabama, chairman, Senate Committee on Labor and Public Welfare, is currently holding hearings on Senate bill 917.

We would greatly appreciate your influence in getting this bill favorably reported to the Senate.

Thank you very much.

Sincerely,

DONALD E. OXFORD, D.D.S.,
Chairman, Council on Legislation.

STATE DEPARTMENT OF HEALTH,
STATE OF OKLAHOMA,
Oklahoma City, Okla., May 18, 1962.

HON. LISTER HILL,
U.S. Senate,
Washington, D.C.

MY DEAR SENATOR: I am writing you in regard to S. 917. As you probably know, dental decay is one of the most prevalent diseases in the country. It runs neck and neck for first place with the common cold. The need for correcting it is colossal, almost unsurmountable. We need S. 917 to do educational campaigns in dental health and hygiene; also to expand our clinical programs to care for those unable financially to secure dental treatment.

I strongly urge you to move a "do pass" on S. 917.

Sincerely yours,

H. ROY GRAVELLE, D.D.S.,
Director, Division of Preventive Dentistry.

[Telegram]

PORTLAND, OREG., May 22, 1962.

HON. LISTER HILL,
U.S. Senate, Washington, D.C.:

This is to reiterate our support for S. 917 and H.R. 4742 expressed in a resolution sent to the entire Oregon congressional delegation June 16, 1961.

OREGON HEALTH OFFICERS ASSOCIATION,
By S. B. OSGOOD, M.D. OFFICERS,
Secretary.

OREGON STATE DENTAL ASSOCIATION,
Portland, Oreg., May 22, 1962.

Senator WAYNE L. MORSE,
U.S. Senate, Senate Office Building, Washington, D.C.

DEAR SENATOR MORSE: It is requested that the enclosed resolution, which was passed at the meeting of the executive council of the Oregon State Dental Association January 21, 1961, become part of the record of the hearings of the Senate bill S. 917 (87th Cong.) pertaining to a grant program for the prevention and control of dental diseases, and for other purposes.

Oregon has a good proportion of dentists to serve the people of the State. However, Oregon has one of the highest dental caries rates in the Nation. There is a marked need for more programs for the prevention and control of dental diseases. About 10 percent of Oregon's population is receiving natural flouride-bearing water or flouridated water. Over 75 percent of Maryland's population is curtailing dental caries through this medium.

There are only three active community supported dental care programs for the dental indigent in the State. There are only two local health departments having dental personnel (dental hygienists).

We feel that this dental grant-in-aid program will assist in providing needed funds for Oregon at the State, local, and community levels.

Very truly yours,

ROBERT J. THOMAS, D.D.S., *President.*

RESOLUTION PASSED BY THE OREGON STATE DENTAL ASSOCIATION EXECUTIVE COUNCIL, JANUARY 21, 1961

Resolved, That the Oregon State Dental Association go on record as approving, recommending and actively supporting the American Dental Association's request to establish a category in the program of Federal grants-in-aid funds to State specifically earmarked for dental public health programs, such funds to be used to support and strengthen basic dental public health services at the State and local health department level and for special studies and investigations concerned with the dental health problem, and in establishing and maintaining adequate measures for the prevention and control of dental diseases;

Resolved, That copies of this resolution be sent to the American Dental Association; the Secretary of the Department of Health, Education, and Welfare; the Surgeon General of the Public Health Service; and to the Oregon elective officials to the Congress of the United States.

UNIVERSITY OF OREGON DENTAL SCHOOL,
Portland, Oreg., April 22, 1961.

HON. WAYNE L. MORSE,
U.S. Senate,
Washington, D.C.

DEAR SENATOR MORSE: It is with some reluctance that I write this type of letter to you. I have never considered myself one of the so-called home State lobbyists, but I believe that the importance of Senator Hill's bill merits at least a word.

Public health dentistry could tolerate and can well use a grant-in-aid program as advocated in the bill S. 917. I know not whether Dr. David Witter has written to you in regard to this legislation, but he certainly should. If he has not, it may be well worth your efforts in your mental manipulations of this bill to seek some information from him.

Being situated at the University of Oregon Dental School and specializing in children, I constantly see the glaring inadequacy of the dental health of the youngsters in this region. The bill per se will be no panacea. We will still have dental discrepancies, but hopefully not as great as are evident presently.

Specifically, we see youngsters at the crippled children's division—cardiac, cerebral palsied, cleft palate, and cast cases to which dental care has been either absent or minimized. This situation, particularly in cardiac, rheumatoid, and nephritic children is intolerable when one sees the sequelae of oral bacterial invasion in these youngsters. The parents are diligent in their efforts, but lack of knowledge on their part and lack of personnel in the outlying areas, who are qualified to advise and administer such cases, places the entire problem in an aura of chaos. Currently, the medical and dental schools, in a joint effort, are attempting to place an individual specializing in pedodontic dentistry into the crippled children's division to serve as consultant member of a team of evaluators and to direct some treatment for patients. Unfortunately, one man will be able to handle but small portions of the task facing him.

On the bright side, we see that this part of the dental health picture and its importance and vital role in the systematic well-being of children has been recognized. Furthermore, an attempt has been started at Oregon to do something about it. Thank God, we are moving ahead, but the rate of movement is questionable.

I have touched on one facet of the multiphased problem of public health dentistry, but it is one of major concern to all of us involved, directly and indirectly, in this area. I feel that a means of training dental personnel and placing them in fieldwork, perhaps under the auspices of the U.S. Public Health or State health agencies, will enhance our position in the area of prevention and hopefully alleviate some of the gross aspects of dental disease.

I would not be a party to asking for support on a fund measure just for the sake of asking. If I felt that there was no need for support in the area of dentistry, I would not certainly write this type of letter. I believe Federal funds must be guarded in their use. However, I do feel there is cause for concern in the area of preventive and public health dentistry and I hope that Senator Hill's bill will receive your support.

If you have the opportunity and time, I would appreciate your views on Senator Hill's bill S. 917. I do believe it has merit, but would surely appreciate your reflections.

Sincerely,

DUANE R. PAULSON, D.D.S.

[Telegram]

UNIVERSITY OF PUERTO RICO,
SCHOOL OF DENTISTRY,
San Juan, P.R., May 24, 1962.

Senator LISTER HILL,
Capitol, Washington, D.C.:

The Puerto Rico Dental Association wholeheartedly supports S. 917 and respectfully request favorable action from your Committee on Labor and Public Welfare that you preside.

Dr. REINALDO GONZALEZ RAMOS, *Secretary.*

[Telegram]

PROVIDENCE, R.I., March 29, 1962.

Senator LISTER HILL,
Chairman, Committee on Labor and Public Welfare, Health Subcommittee,
Senate Office Building, Washington, D.C.:

May I request that the Committee on Labor and Public Welfare give strong support to Senate bill 917 which provides for grant-in-aid for dental public health. Financial support as an impetus to increased dental public health activities is sorely needed in the State of Rhode Island. I would appreciate having these remarks read into the official record of the committee.

JOSEPH E. CANNON, M.D.

MPH Director of Health, Rhode Island Department of Health.

[Telegram]

MEMPHIS, TENN., May 23, 1962.

Senator LISTER HILL,
Senate Office Building, Washington, D.C.:

As present dean of the college of dentistry and formerly executive secretary of the ADA Council on Dental Education, I want to express my support for the Senate bill S. 917 which is under discussion.

Dr. SHAILER PETERSON,

Dean, University of Tennessee College of Dentistry.

THE UNIVERSITY OF TENNESSEE,
COLLEGE OF DENTISTRY,
MEMPHIS, TENN., May 23, 1962.

Senator LISTER HILL,
Senate Office Building, Washington, D.C.

DEAR SENATOR HILL: Prior to coming to the University of Tennessee College of Dentistry last June 1961, I was executive secretary of the Council on Dental Education of the American Dental Association for 17 years. In that position, I was active in preparing much of the testimony and presenting much of the testimony that was given before congressional committees in support of Federal aid for dental education. Since coming down here to this college of dentistry, I am now able to see firsthand the needs of an individual school whereas before I was looking at the entire national picture of dental education.

Both from the information that I had at the national level and also now from a very realistic position as dean of a college of dentistry, I am reinforcing my interest in the need for Federal aid for our professional schools. I am also a member of the NIDR Training Grant Committee and also the USPHS Committee on Training and have gained additional information which points out indelibly the importance of having additional Federal aid available for our dental schools if we are going to be able to continue our education of dental students without reducing the quality of this instruction and also if we are going to be able to maintain the numbers that we are now training.

As you probably know, this is the only dental school in the United States and Canada that utilizes its physical facilities around the calendar and hence is able to graduate students in 36 months as opposed to the 4 years that is normally required. Therefore, this institution is actually trying to provide a program for producing the maximum number of graduates in the shortest length of time; and we certainly realize the need for additional financial support.

I am strongly in favor of the Senate bill No. S. 917, as I have indicated in my telegram that was sent to you today.

If I can be of assistance to you or your committee, I hope that you will feel free to call upon me.

Sincerely yours,

SHAILER PETERSON, Ph. D., *Dean.*

STATE OF TENNESSEE,
DEPARTMENT OF PUBLIC HEALTH,
Nashville, January 4, 1962.

HON. LISTER HILL,
U.S. Senate,
Washington, D.C.

DEAR SENATOR HILL: I understand that hearings are to be held early this year on bill S. 914 which you are sponsoring and which is to establish a dental category in the program of Federal grants-in-aid to States for health services.

The use of grants to stimulate programs in the field of public health has been markedly successful in Tennessee for many years. I am confident that categorical funds for our dental public health programs would be just as successful in developing programs beyond what we have now.

I think it will be of interest to you to know that local official and nonofficial agencies and our State legislature have provided financial support for our dental programs for many years. The Tennessee Legislature was one of the first in the Nation to appropriate earmarked funds for dental public health programs. A dental treatment program for children of low-income families has received local financial support for more than 20 years. I mention these examples to indicate to you that local and State governments in Tennessee are interested in the dental health of our people and especially our children. Enactment of this legislation you are sponsoring would enable us to expand the programs that are now in operation and also institute new programs which will assist in the prevention and control of dental diseases.

I want you to know that I endorse bill S. 914 since I feel its passage can result in better dental health for the people of Tennessee.

Sincerely yours,

R. H. HUTCHESON, M.D.,
Commissioner.

STATE OF TENNESSEE DEPARTMENT OF PUBLIC HEALTH,
Nashville, May 24, 1962.

Senator LISTER HILL,
Chairman, Committee on Labor and Public Welfare,
U.S. Senate,
Washington, D.C.

DEAR SENATOR HILL: I understand hearings are being held on Senate bill 917 to provide grants-in-aid for State dental health activities. I want to assure you and the committee of our keen interest in this bill since we feel its enactment could result in greatly improved dental health for the American people.

This would be done by increased activity in dental and dental public health research, which would give us new and improved methods of preventing and controlling dental diseases which are among the most widespread affecting the American people.

Grants-in-aid for State dental health activities could also result in wider application of the presently proven preventive principles that are not being as widely used as they could be.

If this letter would serve any purpose I will be glad for it to be incorporated into the record of your committee hearings.

Sincerely yours,

A. H. TRITHART, D.D.S.,
Director, Division of Dental Health.

UTAH STATE DENTAL ASSOCIATION,
Salt Lake City, Utah, May 18, 1962.

HON. LISTER HILL,
*Chairman, Committee on Labor and Public Welfare Aid,
U.S. Senate, Washington, D.C.*

DEAR SENATOR HILL: I desire to transmit the favorable support of the Utah State Dental Association for the enactment of Senate bill 917, which proposes categorical grants-in-aid to support dental health programs operated at community level. Such grants will strengthen State and local dental programs and will be in accord with recommendations of the American Dental Association which testified before a U.S. Senate committee urging the establishment of a separate category of grants-in-aid funds under the U.S. Public Health Service Act for the support of State dental public health activities.

Dental diseases affect the population more nearly universally than do other diseases for which earmarked Federal health funds are now readily available. Funds should be specifically earmarked to assist communities in meeting the cost of initiating preventive and incremental care program, particularly for children. Federal assistance should make it possible for communities to provide partial payment for incremental care until time such individuals are able to assume responsibility for their own care.

Such grants-in-aid should enable official health agencies to assert appropriate community leadership in the initiation, planning, and administration of dental care programs, giving first priority to school-age children.

We respectfully urge the Labor and Public Welfare Committee to give favorable consideration to this much-needed legislation and their hearty support for its enactment.

Sincerely,

R. C. DALGLEISH, D.D.S., M.P.H., *Secretary.*

[Telegram]

PORTLAND, OREG., *May 23, 1962.*

HON. SENATOR LISTER HILL,
Senate Office Building, Washington, D.C.:

One thousand boys and girls now in schools throughout Washington State have three strikes against them because of their crippling orthodontic problem. They are shunned, saddened, disheartened, lonely, frustrated, and fearful owing to their unsightly teeth. They go from classroom to classroom each day with lips tightly pulled down to hide their malocclusion which the orthodontist alone can correct and at an average cost of \$1,000.

May God give you courage to speed S. 917 to a safe passage to give these young people a chance in life.

OLIN E. HOFFMAN, D.D.S., M.P.H.,
*Commander, U.S. Public Health Service (Retired), Head, Dental Health
Section, Washington State Department of Health, Seattle, Wash.*

THE STATE OF WASHINGTON, DEPARTMENT OF HEALTH,
Seattle, June 6, 1961.

HON. LISTER HILL,
U.S. Senate, Senate Office Building, Washington, D.C.

MY DEAR SENATOR HILL: I should like to express my appreciation for your introduction of S. 917, and for your interest in holding early hearings on this bill.

Thanks kindly for your interest in dental health.

Yours sincerely,

OLIN E. HOFFMAN, D.D.S., M.P.H.,
Head, Dental Health Section.

THE LEGISLATIVE INTEREST COMMITTEE,
 OF THE DENTAL PROFESSION,
Seattle, Wash., May 26, 1961.

Senator L. HILL,
*Chairman, Labor and Welfare Committee,
 U.S. Senate, Senate Office Building, Washington, D.C.*

DEAR SENATOR HILL: The Washington State Dental Association wishes to express its appreciation to you for the introduction of Senate bill 917 which would authorize categorical grants-in-aid to the States for dental health activities.

This measure, if it becomes law, should be very beneficial to the dental health of the public through the additional research and other activity it would allow for that purpose.

We wish to express our appreciation to you and to urge that hearings be held on this bill, as well as the companion bill in the House (H.R. 4742) so that interested parties may have an opportunity to present their material before your committee.

Very sincerely,

GEORGE D. DORE, JR., D.D.S., *President.*

WHEELING DISTRICT DENTAL SOCIETY,
Wheeling, W. Va., July 17, 1961.

MR. LISTER HILL,
*U.S. Senate,
 Washington, D.C.*

DEAR SIR: We urge your support in behalf of S. 917 in regard to Federal grants-in-aid for State dental public health programs.

Sincerely,

WILLIAM R. GRUBLER, D.D.S., *Secretary.*

WISCONSIN STATE DENTAL SOCIETY,
Milwaukee, Wis., May 22, 1962.

HON. LISTER HILL,
*Senate Office Building,
 Washington, D.C.,*

DEAR SENATOR HILL: I am advised that hearings on S. 917 will begin before the Senate Committee on Labor and Public Health on Thursday.

Enclosed is a copy of a resolution relative to grants-in-aid for dental care adopted by the executive council of the Wisconsin State Dental Society on December 10, 1960.

We would very much appreciate your communicating the text of this resolution to the committee, and trust you will give the views of the dental profession of Wisconsin earnest consideration in your deliberations.

Sincerely yours,

KENNETH F. CRANE,
Executive Secretary.

RESOLUTION OF THE EXECUTIVE COUNCIL, WISCONSIN STATE DENTAL SOCIETY,
RELATING TO FEDERAL GRANTS-IN-AID FOR DENTAL CARE

Whereas U.S. Senator Lister Hill of Alabama introduced a bill into the Congress in 1960 to establish a dental category of the program of Federal grants-in-aid to States for general health activities, and such bill was not enacted, but it is understood that Senator Hill is expected to reintroduce such a bill in 1961, and that State dental health directors, among others, will be called upon to testify to the need of such grants; be it therefore

Resolved, That the executive council of the Wisconsin State Dental Society, as the governing body of a voluntary association comprising all but a minor proportion of the dental profession resident in Wisconsin, go on record as strongly supporting legislation for the above purpose on the basis that it is in the best public health interest of the population as a whole; be it further

Resolved, That the executive council seek the support of the house of delegates and of the general membership of this society in urging upon the State Legislature of Wisconsin the importance of appropriating funds, on the basis of of such Federal grants-in-aid, sufficient in amount to carry out effectively those dental programs which, in the judgment of the dental profession of this State, and in the judgment of appropriate health officials, are realistically in the public health interest; be it further

Resolved, That the commission on dental health shall be delegated by the president to study some of the major areas of dental health and education for which this State does not presently have funds, personnel, or program, so that it may be in a position to recommend to the executive council, and the latter to recommend to the house of delegates, and the general membership of this society, such programs, with recommendations as to priorities, together with an evaluation of the existing State program of dental health and education; be it finally

Resolved, That copies of this resolution, executed by the president and constitutional secretary, be sent to the two U.S. Senators from Wisconsin, to Senator Lister Hill, to Hon. Gaylord Nelson, Governor of the State of Wisconsin, and to the American Dental Association.

THE STATE OF WYOMING,
DEPARTMENT OF PUBLIC HEALTH,
Cheyenne, May 24, 1962.

HON. LISTER HILL,
*Chairman, Senate Committee on Labor and Public Health,
U.S. Senate, Washington, D.C.*

DEAR SENATOR HILL: As director of the division of dental health, may I urge your committee to recommend the passage of S. 917.

The Wyoming State Dental Association strongly reaffirms the policy of the American Dental Association on S. 917.

Would you be so kind as to include these statements into the records of the committee hearings.

Thanks.

Sincerely yours,

T. J. DREW, D.D.S.,
*Director, Division of Dental Health,
Secretary-Treasurer of the Wyoming State Dental Association.*

COMMONWEALTH OF PENNSYLVANIA,
DEPARTMENT OF HEALTH,
Harrisburg, May 22, 1962.

HON. LISTER HILL,
*Chairman, Senate Committee on Labor and Public Welfare,
U.S. Senate, Washington, D.C.*

DEAR SENATOR HILL: This letter is written on behalf of the Association of State and Territorial Health Officers in connection with S. 917 which has to do with dental health and grants-in-aid to the States for this purpose. I understand that your Committee on Labor and Public Welfare is conducting a hearing on this bill on May 24, 1962. As vice president and acting president of the Association of State and Territorial Health Officers, I would appreciate having

the statement of our association concerning this bill incorporated into the record.

State health departments are vitally interested in dental health. Only three States do not have a dental health program. Tooth decay and abnormalities of the structures of the mouth around the teeth are widespread in the United States. The average child in our Nation has about five decayed, missing, or filled teeth. Approximately 95 percent of our schoolchildren have tooth decay. Only two out of five decayed teeth have been adequately filled, according to national studies. The structures surrounding the teeth in the mouth are receiving very little attention; consequently about 40 percent of our children have some dentofacial deformity which should call for orthodontic care, but this care is seldom received. Various studies have shown that there is a considerable amount of chronic infections and their sequelae of the gums and other supporting structure by the time persons reach adulthood.

Public health dental health programs are suffering from insufficient funds. Only 0.7 percent of budgeted expenditures of health departments is spent for dental health. In 1960, the States were spending about \$3.5 million annually for dental health programs. It has been estimated by the Association of State and Territorial Dental Directors that \$17 million annually would be required to meet program and staffing requirements. Five States have no dentists for their dental health programs and 33 States have no dental hygienists. Thus, some of the Federal grant-in-aid money, if available, would be used for helping to train personnel in a field where there is an appreciable shortage of trained personnel.

Few States have been able to obtain adequate funds from State legislatures for dental health activities. Federal aid would encourage additional State dental health appropriations. The use of Federal grants to stimulate activities in the health field has, in recent years, been remarkably successful. Through the stimulus of such grants, States have developed programs considerably beyond what might have been expected had the States been left entirely to their own appropriation activities.

Dental science has already developed effective public health techniques for the prevention and control of the most prevalent of chronic diseases. Yet millions of people are denied this protection because the State and local dental health programs necessary to its provision are understaffed and undermanned. Dental science has developed the instruments and techniques required to meet the peculiar treatment needs of the chronically ill, the handicapped, the mentally disturbed. But dental public health agencies have neither the men nor the money to build the care programs these disadvantaged people so desperately need.

Proponents of better directed dental health education programs must be content with halfway measures. Such important dental health programs as those demonstrating the cytological diagnosis of oral cancer are annually proposed but never undertaken. Epidemiological research—the very bedrock of progress in public health—is beyond the budgetary reach of the dental health staff in community after community, in State after State.

The lack of depth and scope which characterizes dental public health programs today is in no sense the result of a failure of leadership or vision on the part of the administrators of dental public health programs. To the contrary, within the limitations imposed by small staffs and inadequate budgets, the average dental health unit has achieved a remarkable record in terms both of current programs and of long-range planning. But the fact that they have done so well with so little serves to underscore even more emphatically the unnecessary loss in health protection the people of this country have sustained because these agencies could not afford to do more.

The only alternative—to increase the support of dental programs by reducing that now given to other essential health activities—would be self-defeating. For this reason, S. 917, which offers a new source of funds, which provides Federal aid for the specific use of dental agencies, will in essence permit the strengthening of the entire base of public health activity.

It was in recognition of the need for such support that the Association of State and Territorial Health Officers, in October 1960, adopted the following resolution:

"That the Association of State and Territorial Health Officers support or arrange for the initiation of legislation for a categorical grant-in-aid to assist State and territorial health departments in developing adequate dental public health programs, and that the secretary of the association inform the Surgeon General of the Public Health Service, the American Dental Association, and the Secretary of the Department of Health, Education, and Welfare of this recommendation."

There can be no doubt that the public's need for stronger dental public health programs is even greater today than it was in 1960. It is imperative that this need be met.

Because of the very considerable need for improved dental public health programs in connection with diagnosis, treatment, and training of personnel, the Association of State and Territorial Health Officers respectfully requests your committee to act favorably upon the passage of S. 917.

Sincerely yours,

C. L. WILBAR, Jr., M.D.,

Acting President, Association of State and Territorial Health Officers.

AMERICAN ASSOCIATION OF DENTAL SCHOOLS,
Chicago, Ill., May 25, 1962.

HON. LISTER HILL,
U.S. Senate, Washington, D.C.

DEAR SENATOR HILL: It is my understanding that a hearing on S. 917 was held before your Subcommittee on Health of the Committee on Labor and Public Welfare on Thursday, May 24. In view of the interest of the American Association of Dental Schools in the purpose of this legislation, I would like respectfully to request your permission to insert the attached statement in the hearing record.

If you or members of your committee would like additional information or comments regarding the attached statement, I will be pleased to see that they are provided immediately.

Respectfully yours,

REGINALD SULLENS, *Secretary.*

STATEMENT OF THE AMERICAN ASSOCIATION OF DENTAL SCHOOLS

Shortly after the introduction of S. 917 in the 1st session of the 87th Congress, the House of Delegates of the American Association of Dental Schools convened for its 38th annual session. Among the matters considered by the representatives of all of the dental schools in the United States at the association's 38th annual session was the significant contributions to dental health and dental education which could be realized from enactment of S. 917. In order to make the position of the schools of dentistry perfectly clear with regard to this legislation, the following resolution was adopted by a unanimous vote of the house of delegates:

18-61-H. *Resolved*, That the American Association of Dental Schools supports legislation to provide Federal grants-in-aid earmarked specifically for State public dental health activities and to provide authority for project grants to educational and other nonprofit agencies for surveys, studies, demonstrations, and training projects of significance in the prevention and control of dental disease (proceedings, vol. 38, p. 108).

The association is pleased to have this opportunity to record its strong support of S. 917 and to comment specifically on the ways in which the project grant authority contained in the bill could contribute to an improved program of preventing and controlling dental disease. Before proceeding to these comments, however, we would like to make an observation on the categorical grant-in-aid provisions of S. 917.

As has been pointed out by witnesses who appeared before this committee, the magnitude of the dental disease problem is such that solution will demand the closest cooperation of all of the agencies concerned with the dental health of our people. Dental societies at the National, State, and local level, all echelons of our dental public health organization, the various components of the dental auxiliary groups, and the dental education institutions must combine their personnel and resources effectively for an all-out attack on dental disease if we are to expect marked improvement over the efforts which are now being made. To date the efforts which the dental schools and the universities have made to prepare skilled personnel for positions in dental public health have been only partly successful, largely because of the well-known fact that the funds needed to plan and conduct State and local dental public health programs have not been available. Within the past year, several of the dental schools have indicated an active interest in cooperating with dental public health agencies

and dental societies in studying such fundamental problems as how to provide dental care for the chronically ill and handicapped and how to teach the methods of handling these special patients to students now in school. These efforts have been severely handicapped because of a lack of adequate financing. With this one example, and many others could be cited, the American Association of Dental Schools would like to endorse the categorical grant-in-aid provisions of S. 917.

During the past several years, there has been considerable progress in fundamental dental research due, in large measure, to the increased support which has been made available to the National Institute of Dental Research. Although much remains to be done, it is encouraging to note that several of the major dental diseases are becoming better understood and that headway is being made in the clinical application of the biological and physical science discoveries. The dental schools have and will continue to play a major role in the education of dental research scientists and in the conduct of research projects which are so important to the ultimate prevention and treatment of dental disease. We must not forget, however, that continued, vigorous prosecution of dental research is only one of the responsibilities of the dental schools. Our dental schools have the responsibility of educating dentists; they must train or assist with the training of dental hygienists, dental assistants, and dental laboratory technicians; they must provide opportunity for practitioners of dentistry to continue their professional education; and they surely must remain constantly alert to the social and economic factors which influence the ability of any health profession to provide the services for which it is responsible to the public.

The survey of dentistry conducted by the American Council on Education, the annual transactions of the American Dental Association, the proceedings of the American Association of Dental Schools, and the many reports which have been published by the Division of Dental Public Health and Resources of the U.S. Public Health Service all point to the fact that responsible professional and governmental agencies have been concerned with the entire complex of problems involved in providing the amount and quality of dental care which will be needed in the future. These same sources also demonstrate repeatedly the absolute necessity of securing additional financial support to promote educational and sociological research projects in dentistry. We would like to comment on just a few of the projects which could and would be undertaken if project grant authority is established as outlined in S. 917.

1. The American Association of Dental Schools has just established a division of educational research with the assistance of a substantial grant from the Fund for Dental Education, Inc. The basic objective of this division is to plan and promote a continuing program of research on the dental curriculum and dental teaching. In the final analysis, however, the development and demonstration of more efficient curriculum sequences and teaching methods will require the participation of individual educational institutions. Project grants made available under the provisions of S. 917 will help the dental schools, dental hygiene schools, and other interested nonprofit agencies carry on the experimentation which is already overdue.

2. Although the dental societies and dental schools are making greater efforts every year to meet the needs of dental practitioners for continuing education, there is serious and immediate need for studies to determine how this type of education can best be provided, where it should be given, how it can be financed, and what subjects are of most importance to the practicing dentist.

3. The President and the Congress have demonstrated their recognition of the need for additional educational facilities for health personnel and legislation is now before both the Senate and the House of Representatives to assist with the construction of dental schools. Studies have been made by agencies of the dental profession and the Division of Dental Public Health and Resources to suggest guidelines for the space and equipment required for modern dental education, but there is need to continue these studies in more depth and to establish projects to evaluate some of the newer concepts of space utilization which have already been identified.

4. Several of the dental schools have already become involved in studies and projects to measure the efficiency of the private dental office and the equipment which is now in general use. Those projects now in progress need expanded support, and there should be concurrent efforts started in several other dental schools, for any discovery in this area which is adaptable immediately to dental

practice could have a profound impact on the anticipated dental manpower shortage.

5. Within the past year projects have been started in several dental schools to study the most effective methods of providing dental care for bedridden patients in homes and hospitals. Enactment of S. 917 would help both the dental public health agencies and the dental schools to intensify their investigation of this important project. It is obvious that the sooner the profession finds the answers to the methods and procedures deemed most effective for treating the special patient, the sooner will the dental schools be able to incorporate these concepts in the dental curriculum so that all future dental graduates will be prepared to care for the chronically ill or handicapped patient.

6. Studies are needed to identify the factors which influence students to enter a career in dentistry. As has been true in several of the health professions, the quantity and quality of applicants to dental schools has diminished over the past few years. Vigorous efforts are being made by the dental profession to reverse this trend but, to date, we have not been able to analyze adequately the reasons why young, capable students are choosing other careers in preference to one of the health sciences.

7. Various projects related to improving the effectiveness of the utilization of dental auxiliary personnel are in progress but, here again, this area of investigation shows so much promise that greatly increased support should be provided at the earliest possible time.

These are just a few of the examples of projects which have already been identified as being worthy of intensive study but for which financial support in anything approaching adequate amounts is not now available. There is no doubt but that additional, and perhaps even more fruitful areas of study will be discovered as these projects proceed. However, in view of the critical nature of the impending dental manpower shortage, we cannot allow these important studies and projects to lag behind because of a lack of adequate funds. The necessary professional and scientific personnel are available, interest and motivation exist, and considerable financial support has already been provided by the profession, the universities, and the dental industry, and some of the foundations. The American Association of Dental Schools would like to urge the enactment of S. 917, through which the Federal Government could become a partner in the cooperative effort to solve the problems of the prevention and control of dental disease.

THE AMERICAN BOARD OF DENTAL PUBLIC HEALTH,

May 22, 1962.

HON. LISTER HILL,
*Chairman, Subcommittee on Labor and Public Works,
Committee on Appropriations, Washington, D.C.*

DEAR SENATOR HILL: The American Board of Dental Public Health is a dental professional agency created in 1950 for the purpose of reviewing and passing upon qualifications of candidates for practice of the specialty of dental public health. It was established under the sponsorship of the American Association of Public Health Dentists and the American Dental Association. Under its charter, the board maintains a continuing interest in all aspects of dental public health problems, and of programs for the prevention and control of dental diseases and disorders. Accordingly, based upon thorough study and understanding of the dental health needs of the population in this country, and a very real appreciation for the almost insoluble problems which confront and impede official health agencies in their efforts to implement effective dental public health programs, the board from its inception, has endorsed and supported consistently the concept of a Federal categorical dental grant-in-aid to States as the mechanism for bringing about substantial improvement in the dental health of the population.

Senate bill 917, introduced by you in the 2d session of this 87th Congress is a soundly conceived legislative proposal, the enactment of which is long overdue from the standpoint of its urgency and potential impact on dental diseases and disorders. The funds which would be appropriated under this legislation would support dental health activities of official State and local health departments in the conduct of a wide variety of programs for the prevention and treatment of dental illness, and for essential public health research into problems relating to causes and control procedures. There exist today procedures and techniques

for the care of mentally and physically handicapped segments of our population which would be applied rapidly once funds were available.

The diplomates of the American Board of Dental Public Health are sensitive to the implications of this all-important bill in providing a vigorous and healthy stimulation and assistance to official health agencies at the State and community level in their efforts to improve dental health, and thereby contribute to a dramatic reduction in a burden of illness which currently costs the Nation over \$2 billion annually. The American Board of Dental Public Health wishes to emphasize its complete endorsement of S. 917, and the specific provisions of this legislation, and appreciates this opportunity for making clear its position in support of the bill.

Sincerely yours,

JOHN T. FULTON, D.D.S., M.P.H.,
Vice President.

SOUTHERN BRANCH OF
THE AMERICAN PUBLIC HEALTH ASSOCIATION,
Birmingham, Ala., April 26, 1961.

HON. LISTER HILL,
*Senate Office Building,
Washington, D.C.*

DEAR SIR: For your information and consideration, I am enclosing copy of a resolution adopted by Southern Branch, American Public Health Association, at its annual meeting held in Louisville, Ky., April 12-14, 1961.

Sincerely yours,

GEORGE V. TRUSS, *Executive Director.*

RESOLUTION ADOPTED BY THE SOUTHERN BRANCH, AMERICAN PUBLIC HEALTH ASSOCIATION AT ITS ANNUAL MEETING IN LOUISVILLE, KY., ON APRIL 13, 1961

Whereas dental diseases are among the most prevalent diseases affecting mankind; and

Whereas public health measures are effective in preventing and controlling dental diseases and abnormalities; and

Whereas lack of funds continue to be a deterrent to development of adequate dental health programs in the States and local communities; be it

Resolved, That the Southern Branch, American Public Health Association, recommends that categorical Federal grant funds be made available to State health departments for the improvement and extension of basic dental public health services in States and local communities; be it further

Resolved, That the Southern Branch, American Public Health Association, supports Senate bill S. 917 and companion bill H.R. 4742, to amend section 314 of the Public Health Service Act to provide a grant program for the prevention and control of dental diseases; be it further

Resolved, That copies of this resolution be sent to the American Dental Association, American Public Health Association, Association of State and Territorial Dental Directors, American Association of Public Health Dentists, the Surgeon General of the Public Health Service, and to each Senator and Representative in the Congress from the States comprising the southern branch.

PREPARED STATEMENT OF THE NATIONAL HEALTH FEDERATION, SAN FRANCISCO, CALIF.

We wish to compliment the chairman of both the Subcommittee on Health Legislation and the parent Labor and Public Welfare Committee, the Honorable Senator Lister Hill of Alabama for his lifelong interest and service in matters of health of American citizens. We share this interest. A country can remain strong and free only if its citizens are healthy and strong.

It is our understanding that S. 917 was introduced by the chairman at the request of the American Dental Association, who favor the bill. The opponents of fluoridation have tried, unsuccessfully, for many years to have the basic issue resolved which this bill raises. The basic question involved in the bill is whether or not it is a proper function of the Federal Government to intervene in the field of dental hygiene. We feel it is not except in communicable disease that cannot be controlled at a State level.

Fluoridation is the key issue. It is not even mentioned in the language of the bill, but it was made abundantly clear by the witnesses supporting the bill during oral testimony, Thursday, May 24, that it was their intention to use the funds that this bill authorizes to "educate" the people of America to the need and value of mass fluoridation of community water supplies for the prevention of tooth decay.

In America we are ruled by law and precedent. Fluoridation has become a testing ground to see if an American precedent of "limited constitutional government" should be broken and if the power of Government should be expanded.

The precedent in America has been to allow freedom of choice in matters of health consistent with safety. The members of the National Health Federation believe in freedom of choice in matters of health where the exercise of that freedom does not endanger the life or health of another and thereby deny him the same right or freedom. We defend the American precedent of freedom and declare it applies with the same logic in matters of health as it does in matters of religion. When we defend freedom of choice in matters of health, we have to answer the problem of safety.

We believe there are many proper areas for the police power of the State to be exercised where freedom of choice by some individuals has clearly endangered the lives and health of others, and thereby must be controlled, or curbed. Air pollution, water pollution, waste elimination, poison sprays, food additives, preservatives, colorings, etc., are proper areas of concern by Government.

A key word to remember in considering the proper function of Government in health is the word "communicable." It is also expressed by the phrase—"hazard to others."

It is obvious that the power of quarantine should be considered as a proper function of the State, for no person has, in the exercise of his freedom of choice, the right to endanger the life and safety of another.

There are some dental diseases that would call forth the proper exercise of police power in their control. Trenchmouth, if communicable, would be an example. The control should be at the closest level to the individual that is consistent with solving the problem.

Now we wish to emphasize the fact that tooth decay is not contagious. An individual, exercising his freedom of choice, however poorly, in preventing tooth decay, is not a clear and present health hazard to his neighbor who might be more wise or prudent. The "benefits" of fluorine are available to those who wish them in several different forms, including, but not limited to, fluorides in drinking water on an individual basis for those who are convinced there is some special merit in taking it in this form.

There are certain fundamental areas of health behavior that should be free from governmental control. Federal control of the toothbrush is improper. How a man cares for his teeth is no more a proper concern of the Federal Government than how he combs his hair, so long as he does not become a health hazard to his neighbor.

The American Constitution and tradition is based on limited Government control of individuals. Fluoridation of public water supplies is extending the concept of public health way beyond its proper function or concern. Chlorination of water is the treatment of water to prevent communicable disease. Fluoridation is not for treating or purifying water, but is for treating individuals—and for a noncommunicable disease. If we shatter precedent and pass legislation that acknowledges that the Government can properly enter any area of treatment or prevention of noncommunicable disease, it will completely destroy the concept of a limit to Government in matters of health. The ultimate could be—"Be well, or go to jail." It is just as improper to force a man to be healthy as to be holy.

We wish to compliment the American Dental Association for its excellent service to America as an organization of dentists. We are aware of the magnitude of the problem of dental caries in America. We support the efforts and work of the ADA to improve the dental health of America within the framework of freedom of choice. We have the same goal. We respectfully differ in our approach to the goal in respect to the function or role that the Federal Government should play.

A SOCIALIZED MEDICINE APPROACH

It is understandable that a close, daily contact with a preventable disease should give rise to impatience, if not intolerance with the traditional American practice of education and persuasion. There is a temptation to lower the standard of freedom for just this one exception.

The American Dental Association has rather consistently supported the stand of her sister organization, the American Medical Association, in keeping socialized medicine out the front door. And yet, both organizations have endorsed a back door approach to socialized medicine.

In an editorial, the Santa Ana Register pointed out:

"Medicine which you must take whether you want it or not, which you must pay for whether you want it or not, is socialized medicine, isn't it?"

REPRESENTATIVE BARING IS OPPOSED TO S. 917

The Honorable Representative Walter S. Baring, of Nevada, on September 27, 1961, warned against Senate bill S. 917. He said: "Another aspect of this fluoridation problem is need to bring to the attention of this Congress the unethical methods used in promoting fluoridation, starting with the fourth annual conference of the State dental directors and the Public Health Service held in Washington in June 1951, culminating in a now new accelerated high-pressure program of the U.S. Dental Public Health Division that will be conducted through the use of undetermined funds now being requested, under House bill 4742 and Senate bill 917.

"Mr. Speaker, these are not good bills. They would permit uncontrolled use of Federal funds for promotional schemes not in the best public interest."

Attached to this statement is a reprint from the Congressional Record. I should like to request that it be printed in the record of this subcommittee hearing. It is the full text of Congressman Baring on this matter of fluoridation.

Representative Baring has pointed out that "during the past year voters representing some 2,500,000 water users in 43 out of 56 cities rejected fluoridation with little more than about 50,000 having accepted."

We submit that the overwhelming rejection by the American people is not a result of "lack of education." In areas where fluoridation comes to referendum, the newspapers, radio, TV, etc., have usually carried both sides of the argument, and never the side against it without the side in favor. In some cities the proposal has been defeated several times. Citizens who oppose the measure on religious or political or health grounds are required to finance both the promotion and opposition to fluoridation because their tax money has been used to promote fluoridation at the Federal level. S. 917 would extend this injustice.

FEDERAL LEVEL PROMOTION DENIED

This, however, has been denied in the past when constituents have petitioned their Congressmen for redress of this wrong. With monotonous regularity, the staffs of Congressmen have answered requests for relief from Federal promotion with a stock answer supplied to them by the Public Health Department. "We believe this matter should be decided at the local level." Representative Baring and others have pointed out that the promotion for fluoridation does not originate at the local level. Fluoridation cannot stand the public gaze at the local level.

The proper course of action at this time should be to strictly prohibit any more promotion of any kind at the Federal level, rather than to take the exact opposite course, outlined in S. 917 and increase the Federal support in an all-out program. Representative Baring's House Resolution 516 expresses the obvious will of the people, and we respectfully request that the substance of it be included in S. 917 if the bill is not defeated. His resolution states, and we recommend as an amendment to S. 917, the following:

"* * * The Secretary of Health, Education, and Welfare, in the administration of the laws of the United States relating to the public health, should not approve any program of a public or private agency to promote mass fluoridation of potable water."

Up until now we have not submitted with this statement any of the volumes of evidence available which indicates that fluoridation is not as safe or effective as the proponents declare. We do not believe this to be the main issue. Our

entire argument until this point will stand regardless of whether or not fluoridation will accomplish what its most enthusiastic proponents claims it will. Medical beliefs, and dental beliefs, and techniques change from age to age, but the principle of freedom stands through history as the safest of all principles to defend.

John Stuart Mill has said:

"It often happens that the universal belief of one age—a belief from which no one was free, nor without extraordinary effort of genius could, at that time, be free—becomes to a subsequent age so palpable an absurdity that the only difficulty is to imagine how such a thing can ever have appeared credible."

It is conceivable that a future age may disdainfully look at our American preoccupation with fluoridation as the key to dental disease. Some other nations have already rejected fluoridation. History may even record that England's newly declared tax on sugar, soft drinks, candy, etc., is a more direct attack at the fundamental cause of tooth decay. In such an eventuality, it would record as tyrants or fools those lawmakers who disregarded or trampled the rights of those citizens who preferred to exercise their freedom of choice in this fundamental matter. It would record as statesmen those who carefully protected individuals rights to freedom of choice in matters of health where the exercise of that freedom does not endanger the life or health of another and thereby deny him the same right or freedom.

Thousands of pages of testimony could be submitted at this point laboring the questions of toxicity, allergy, and chronic poisoning which can result from repeated exposure over a long period the toxic agent, fluorine, which accumulates in the body of different individuals at vastly different rates. Hundreds of physicians and dentists and scientists now join Dr. George Waldbott, M.D., FACP, who declared: "As a physician I am opposed to fluoridation because I am afraid of the hazards, as a scientist I am impressed by the contradictory evidence, and as a citizen I am shocked at the methods of promoting it."

I am making available to the clerk of the committee for the use of any committee members who wish to investigate the overwhelming evidence against fluoridation the book, "The American Fluoridation Experiment" by F. B. Exner M.D., and G. L. Waldbott, M.D., and other studies and works by nationally and internationally recognized authorities which disprove and discredit the fluoridation thesis.

I further place at the service of the Senate and House the facilities of the Washington Office of the National Health Federation to secure additional literature or answer any further questions on this problem.

The Washington phone number of the NHF is Republic 7-2333. Thank you.

[From the Congressional Record, Monday, Oct. 16, 1961]

KEEP PUBLIC DRINKING WATER PURE

(Extension of remarks of Hon. Walter S. Baring of Nevada, in the House of Representatives, Wednesday, September 27, 1961)

MR. BARING. Mr. Speaker, I feel it is of utmost importance that I focus the attention of this Congress on an issue which is sorely dividing our Nation at so critical a time when our very existence is dependent upon our ability to strengthen our national unity.

I refer to a program launched by a subagency in the Health, Education, and Welfare Department of this administration to promote fluoridation throughout cities, towns, communities, and all States of this Nation.

During the past year voters representing some 2,500,000 water users in 43 out of 56 cities rejected fluoridation with little more than about 50,000 having accepted.

Water is a prime necessity for life. All people are dependent upon pure, uncontaminated water. The addition of any substance to a public water supply for the purpose of affecting the bodies or mental function of the consumer establishes a dangerous precedent and preempts the inalienable right of the individual to determine what shall be done to and with his body as long as in the exercise of that right he does not infringe upon the equal rights of his fellow citizens.

An article which appeared in one of the most recent medical publications confirms that damage to bones can result from fluoride which occurs in natural water at a level as low as 0.8 part per million. The U.S. Public Health Service

claims on one hand that no harm can result from natural fluoride water as high as 8.0 parts per million, yet they require many communities where this occurs to reduce the fluoride content when it exceeds 1.5 parts per million—or abandon the source of supply. This clearly demonstrates that the U.S. Public Health Service itself realizes that the margin of safety is either narrow or nonexistent.

To use the very words of Dr. Walter L. Bierring, M.D., past president of the American Medical Association:

"Prominence in the cause of disease is being given to man's management of the health hazards connected with air pollution, stream pollution, fluoridation, and radiation."

Fluoride additives have been consumed at an increasing rate over the past 50 years. Changes in disease pattern during that same period of time have not been explained away by medical science.

It is a fact that those who want their children to have fluoride can give it individually, in measured doses, with greater safety, greater reliability than if it were put into public water supplies.

Once the precedent of adding fluoride to the public drinking water has been established, there is almost no limit to the possibilities for the introduction of all manner of drugs. We may open a door which we will never be able to close.

Past errors should have taught official agencies that they should not assume an air of infallibility and an attitude of indifference to public wishes.

Among the many examples which have proven to be "human time bombs" we might cite the approval and use of radon, of thorium, and of iodide in public drinking water for the prevention of goiter, with disastrous results. More recently, the stilbestrol incident, involving a cattle fattening hormone, and the cranberry weedkiller pointed up the justification of the demand by the public for protection from introduction of unnecessary and unwanted chemicals into products intended for human consumption. When the harmful effects of these chemical agents, previously approved for use by an administrative agency of the Government, were brought to national attention, the then Secretary of Health, Education, and Welfare, Arthur S. Flemming, in ordering discontinuance of the use of stilbestrol and the cranberry weedkiller, stated:

"While the argument is going on, the consumer should not, in effect, be asked to serve as a guinea pig. The consumer should never be asked to take a risk of this kind."

I submit that this is the kind of action the Nation is entitled to in the case of fluoridation, especially when there are scientists of Nobel award stature who question the safety of fluoridating public water supplies.

The Association of American Physicians and Surgeons, composed of over 20,000 members of the American Medical Association, condemned mass medication, including fluoridation and the use of the public water supply as a vehicle for drugs. The Medical-Dental Committee on Evaluation of Fluoridation, sponsored by over 1,600 physicians, dentists, and scientists, have critically studied the fluoridation proposal and have shown that it is not safe, that its efficacy has not been demonstrated. They have also shown many reasons why prolonged intake of fluoride may lead to serious chronic conditions for some people. Fluoridation runs counter to the historic policy of the medical profession in maintaining the doctor-patient relationship.

Because of the very important fact that each individual reacts differently to medication, only a physician can determine when fluoride administration should be reduced or terminated.

Another aspect of this fluoridation problem is a need to bring to the attention of this Congress the unethical methods used in promoting fluoridation, starting with the fourth annual conference of the State dental directors and the Public Health Service held in Washington in June 1951, culminating in a now new accelerated high pressure program of the U.S. Dental Public Health Division that will be conducted through the use of undetermined funds now being requested under House bill 4742 and Senate bill 917.

Mr. Speaker, these are not good bills. They would permit uncontrolled use of Federal funds for promotional schemes not in the best public interest.

Furthermore, this unethical promotion, among other things, now takes the form of aiding certain questionable actions on the part of many State boards of health. These boards while working closely with the U.S. Dental Public Health Division, to impose fluoridation upon an unsuspecting public, are actually supplementing directives which originate at the U.S. Public Health Service. The

results are not only misleading in content but, by misrepresentation and distortion, tend to convey to local communities that fluoridation of public water supplies is imperative.

The U.S. Public Health Service has aggressively, through the use of taxpayers' money, promoted fluoridation throughout these United States with grants-in-aid inducements. Fluoridation projects have been underwritten by/or subsidized with Federal funds.

The American Dental Association through close coordination with the U.S. Dental Public Health Division has coercive access to control of vast Federal health funds. It has for years been persistently promoting fluoridation on a national scale, using promotional methods not in accord with the finest American tradition.

Free expression of opinion is being prevented among physicians and dentists; publication and exchange of scientific data among scientists and members of the professions is inhibited by threat of retaliation and economic reprisals. Dentists opposed to fluoridation have reason to fear disciplinary measures from their local dental societies.

When approximately some 60 million people have rejected fluoridation, including those in 100 cities which discontinued it after a trial because of damage to health and property; and when 100 million Americans are now facing possible fluoridation of their drinking water, I believe a most serious Federal policy problem exists.

Our citizens have certain fundamental and constitutional rights. The sooner they are recognized, the sooner we shall resolve the fluoridation controversy. These rights must be expressed as:

First. The right of every citizen to a water supply free from any drug or chemical not required for the purification thereof.

Second. The right of every citizen to a freedom of choice in matters concerning his health so long as this choice does not infringe upon the rights of others.

Third. The right of the professional person, particularly the physician and dentist and scientist, to investigate and to speak freely according to conscience, without fear of censure, and/or reprisal.

I further submit that this program which would treat American citizens as statistical averages rather than individual human beings is needlessly provoking antagonism toward an otherwise effective and important agency of Government. Promotional fluoridation harassment and intimidation of the public is disturbing the tranquility of this Nation at a time when we can least afford it.

Many letters received by the Greater New York Committee Opposed to Fluoridation, from citizen groups representing some several million people of this Nation, are pleading that something be done to combat at the Federal level this promotional menace of forced fluoridation. Certainly when citizens have demonstrated unmistakably their rejection of fluoridation, and when there exists substantial disagreement within the scientific and medical professions as to the safety and efficacy in the fluoridation of potable water, it should not, it must not, be supported at a Federal level.

(Reprinted by Greater New York Committee Opposed to Fluoridation, Inc.)

The CHAIRMAN. If no one else wants to be heard at this time the subcommittee will stand in recess.

Before doing so, we want to thank each one of you for being here today. We very much appreciate it.

(Whereupon, at 12:15 p.m., the subcommittee adjourned, subject to the call of the Chair.)



NIH LIBRARY

Library
National Institutes of Health
Bethesda 14, Maryland



<http://nihlibrary.nih.gov>

10 Center Drive
Bethesda, MD 20892-1150
301-496-1080

DEMCO
PAMPHLET BINDER
Lithomount

NIH LIBRARY



4 0091 7309

NIH LIBRARY



NIH LIBRARY

3 1496 00197 9684